_____File _____Send

VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY

1007 E. Wells Street, South Haven, MI 49090 * Phone: (269) 637-5297 Fax: (269) 637-9238

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Customer Name:_____ Date of Birth: _____ Case #:_____

Please indicate the name the file would be under if different than the name listed above:_____

I, (Name of Authorizing Person) _____hereby voluntarily consent and allow

Van Buren Mental Health Authority **AND** RECORDS DEPOSITION SERVICE, INC. PO BOX 5054 SOUTHFIELD, MI 48086-5054

P: 248-357-3330 F: 248-357-3337

to exchange between themselves confidential information, as specified, from the medical record of the customer listed above. Specific information to be released: (**THIS RELEASE DOES NOT INCLUDE HIV OR SUBSTANCE ABUSE INFORMATION UNLESS SPECIFICALLY INDICATED.**) For substance abuse records I understand further disclosure is prohibited under FR42CRF Part 2.

Under Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure): I understand the minimum amount of information necessary to accomplish the purpose will be released.

Purpose of disclosure: FOR DISCOVERY BEFORE TRIAL

I specifically do not wish for the following information to be released:_____

My signature indicates that I know what information is being released and the reason for such release has been satisfactorily explained to me in terms I understand and I have been allowed to ask questions. *I understand that this information will be disclosed* from my clinical records, which are confidentiality protected by federal and state law.

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258 of 1974 as amended, Sections 748.749, and 750). The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. This authorization is in compliance with Title 42 of the Code of Federal Regulations Part II, which also prohibits disclosure.

This consent form expires on _____ (not to exceed one year) I know I can revoke or change my mind at any time and in that event, the date will be documented on this form.

The above confidential information may be released in the following forms: (initial)

_____**WRITTEN** _____**VERBAL** _____**ELECTRONIC**

ALL BLANK SPACES MUST BE FILLED IN (EXCEPT SIGNATURES AND DATES) *PRIOR TO SIGNING THIS FORM.*

I understand refusal to sign this form will not affect the ability to obtain service.

_____ _____

Witness Signature (Date) Customer Signature (Date)

_____

Legal Representative Signature (Date) ☐ Parent ☐ Guardian ☐ Other _____Relationship

Witness is responsible to assure informed consent was granted by a competent client, parent, Court empowered guardian or legal representative, under *MDMH Emergency Rules R -330.7003. R 330 (5) R 330.6011 (3) and VBCMHA policy.*

☐ Authorization withdrawn or invalid. Staff Name:_____ Date withdrawn:_____

Note: The Agency Releasing Information Should Retain The Original Signed Release Form