COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY
AUTHORIZATION FOR RELEASE OF INFORMATION

Name:	Date of Birth:	Case No.

I authorize and request **COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY**

Street:	City:	State:	Zip:	Phone:	Fax:
376 E. Apple Avenue	Muskegon	MI	49442	(231) 724-3699	231-724-3659

to: (check one) release to ☑ obtain from ☐ exchange with ☐ the indicated facility/designee the following information:

mental health treatment records; financial records; substance abuse; serious communicable disease or infection information (HIV/AIDS, tuberculosis and venereal diseases); and/or information obtained from other health care providers/agencies. **(Client or legal representative may line through and initial above any information not authorized for release.)**

Specify the facility designee with whom the information is to be shared:

Facility/Designee Name:				
RECORDS DEPOSITION SERVICE, INC.				
Street:	**City:**	**State:**	**Zip:**	**Phone:**
P.O. BOX 5054	SOUTHFIELD	MI	48086-5054	248-357-3330

Is this the client's primary health care provider? Yes ☐ No ☐

SPECIFIC TYPE OF INFORMATION TO BE RELEASED:

- ☐ Both Medical/Treatment and Financial Records
- ☐ Medical/Treatment Records
- ☐ Financial Records
- ☐ Court/Legal Records
- ☐ Educational/Vocational Records
- ☒ Other (Please specify below)

If possible, specify the exact information **(required for substance abuse)**:

PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

SPECIFIC PURPOSE FOR RELEASE (MCL330.1748 (4)): ☐ Coordination of Care ☐ Assistance with Benefits ☒ Other (please specify below)

FOR DISCOVERY BEFORE TRIAL

This authorization is good for one year from the date of signature, unless otherwise specified below. I understand that I may withdraw this authorization at any time, except to the extent that the program authorized to make the disclosure has already taken action in reliance on it. If the client has been legally mandated into treatment and this authorization is to the criminal justice system, it will remain in effect and cannot be revoked until the client has been released from that mandate.

Other date, event, or condition for expiration of authorization:

Client Signature	Date	Witness	Date
Parent/Legal Guardian Signature	Date	Witness	Date
Personal Representative (for Deceased Client)	Date	Witness	Date

The information disclosed under this authorization is confidential and is protected by federal confidentiality rules (42 CFR Part 2 and 45 CFR) and/or the state Mental Health Code. It is not to be disclosed further, **including to the client**, except: 1) by officers of the court in connection with their official duties; 2) by written consent of the person to whom it pertains (or the person's legal representative); 3) as otherwise allowed by 42 CFR Part 2 and 45 CFR. Please note that for clients receiving substance abuse services, 1) a general authorization for release of medical or other information is not sufficient; 2) the federal rules prohibit using the information for criminal investigation or prosecution of the client.