Ascension Genesys Hillside Center for Behavioral Services
8435 Holly Rd. Grand Blanc, MI 48439
Phone: 810 603-8800 Fax: 810 579-7222

ID#_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize _____
(Please print)

at _____
Address *City* *State* *Zip Code*

To release and/or exchange information contained in my electronic medical record (or that of my minor child, _____) to the person(s) or organization listed below. Information may include any
(please print)
of the following:

Alcohol and drug abuse records protected under regulations provided in 42 Code of Federal Regulations, Part 2, psychiatric or psychological service records, and social work records, including communications made by me to a psychiatrist, psychologist, social worker, or any other professional who examined me. Information regarding communicable diseases and serious communicable diseases and infections as defined by the Michigan Department of Health Rules, which can include venereal disease, tuberculosis, HIV, AIDS, or ARC.

1. **Name, title, address and organization to whom release or exchange of information is to be made:**

Name/Organization: RECORDS DEPOSITION SERVICE, INC. Phone: 248-357-3330

Address: PO BOX 5054, SOUTHFIELD, MI, 48086-5054
City State Zip Code

2. **Specific type of information to be disclosed** *(Client must initial next to each box that is checked)*:

☐ ___ Verbal Communication	☐ ___ Therapist Intake	☐ ___ Discharge Summary
☐ ___ Letter	☐ ___ Psychiatric Evaluation	☐ ___ Recent History & Physical
☐ ___ Sick Leave / Disability Papers	☐ ___ All Records	☐ ___ Lab Work
☐ ___ Medication Sheet	☐ ___ Most Recent Hospitalization	☐ ____Other_____

3. **The purpose and need for disclosure:**

☐ Coordination of Care	☐ Determination of benefits
☐ Referral of Services	☐ Legal Proceedings
☐ Case Planning	☑ Other PRE TRIAL DISCOVERY

4. I understand that the information disclosed is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient from making any further disclosures of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2.
5. **Revocation of Authorization:** I may revoke this authorization at any time by written notice to the above named individual or organization, except to the extent that the person or organization that is to make the disclosure has already acted in reliance upon it.
6. **I understand that this authorization is voluntary and is not a condition of treatment. Without expressed revocation, this authorization expires for the following specified reason(s), whichever is later (check <u>one</u> box):**

☐ Date: [Six (6) months from date of discharge unless specified]: _____
(Specified date)

☐ Event: _____

☐ Condition: Once the specific information is released, no further information can be disclosed pursuant to this authorization.

Client Signature	Date	**Client Name**	**Date of Birth**
Witnessed By	Date	**Client Phone #**	
Parent/Legal Guardian Representative*	Date	*Proof of guardianship must be presented and on file.	