Cherry Health

Authorization (Permission) to Release Health Information

Patient name _____ Date of birth ___ / ___ / ___ ___ ___ ___

Last four digits of Social Security # ___ ___ ___ ___ Telephone (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

Place of treatment:

_____

_____

_____

Ph # _____ Fax # _____

Records may be released to:

_____

RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI, 48086-5054

Ph # 248-357-3330 Fax # 248-357-3337

Information requested:

☐ Entire health record

☐ History and physical ☐ Lab reports ☐ Immunizations ☐ Billing, invoices and statements

☐ Clinic notes ☐ X-rays ☐ EEG/EKG ☐ Dental films (specify) _____

☐ Information about visits with previous providers and/or treatments by other providers _____

☐ Records related to _____

Dates of treatment: _____

By initialing each of the following, I allow the release of the specially protected health information.

_____ Information about communicable diseases and infections including sexually transmitted infections (STIs), tuberculosis (TB), hepatitis B, HIV/AIDS, HIV testing, AIDS related Complex (ARC) and _____ (specify other if known)

_____ Alcohol and substance use disorder treatment information

_____ Behavioral health treatment records, including conversations between myself and a social worker or psychologist

_____ DNA test result of _____ (Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

Reason for sharing information:

☐ Attorney/legal ☐ Insurance ☐ Continued care ☐ Transfer new provider/reason _____

☒ Other PRE TRIAL DISCOVERY

☐ Coordination of care with verbal and/or written exchange of information with individual listed above
I give permission for my behavioral health provider, my primary care provider and my health plan to routinely exchange information regarding my mental health/substance use disorder treatment and medical health care.

My permission will end after 12 months, or if the following situation happens:

_____

I understand that:

- the sharing of my health information will follow state and federal laws and regulations.
- I can take back (withdraw) my permission in writing at any time. The withdrawal will not apply to previously released information. It will only apply to any releases made in the future.
- this authorization includes verbal, written and electronic communication.
- the information released is for the specific purpose stated above. However, once it is shared, it is no longer protected by HIPAA and may be re-disclosed by the agency that received the information.
- Cherry Health may not withhold treatment, determine payment, or prevent health care enrollment based on whether or not this authorization is signed.

Authorization

I certify that I read or understand, and write in English. I have read or another person has read to me the above authorization. I fully understand the above consent written in English. I have had my questions answered. All blanks were filled in before I signed the consent.

_____

Patient/Parent/Legal Guardian Signature Date

_____

Relationship to patient Witness (second witness if signed with an "X") Date

This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [C.F.R. Part 2]) and Michigan Mental Health Code. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of health information is NOT sufficient for this purpose.