Authorization to Disclose and/or Obtain Confidential Information

Easterseals MORC
2399 E. Walton Blvd.
Auburn Hills MI 48326
PHONE: (248) 475-2150 FAX: (248) 475-6372 EMAIL: Reception_FS-AH@essmichigan.org

Name: _____ D.O.B: _____ Case #: _____

Easterseals MORC is authorized to (CHECK ALL THAT APPLY): ☐ THIS AUTHORIZATION WAS REVOKED ON _____

☒ Disclose minimum necessary information to the person or organization/name below for the uses listed.

☒ Obtain minimum necessary information from the person or organization/name below for the uses listed.

Name:			
Agency / Organization: Records Deposition Service			
Role: (Emergency Contact, Primary Care Physician, etc.) agent for Attorney		Email Address (optional): requests@recdep.com	
Phone Number: (248) 357-3330	Fax Number: (248) 357-3337		
Address: P.O. Box 5054	City: Southfield	State: **MI**	ZIP: 48086-5054

Information to be disclosed (CHECK ALL THAT APPLY):

☐ All Easterseals MORC records ☐ Person Center Planning Documents ☐ Progress / Contact Notes
☐ Assessments ☐ Medication List / Medication History ☐ Lab / Test Results
☐ Psychiatric Evaluations ☐ Medication Review / Evaluation & Management Notes ☐ Housing Documents
☐ Financial information ☐ Other: _____
☐ Information as specified in Crisis Plan/Wellness & Safety Plan or as necessary to resolve a medical or psychiatric emergency

Reason(s) for disclosure (CHECK ALL THAT APPLY):

☐ Ongoing communication with family or significant other ☐ Continuation / Coordination of Care ☐ Disability determination
☐ Emergency Contact ☐ Diagnostic/treatment planning ☐ Referral
☑ Other: legal discovery

I request the following restrictions on this specific disclosure: _____

I understand the information to be released or disclosed may include information relating to communicable/sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), mental health and/or substance use. If you request any restrictions on disclosing this information, please list the specific restrictions and sign below: _____

Signature _____ Date _____

I understand that:

- I may cancel/revoke this authorization at any time unless Easterseals MORC has previously disclosed information related to this authorization. I understand that I must make this request in writing and that it does not start until one (1) business day after Easterseals has received the request.
- This authorization is valid only for the information, organization, person(s), and use(s) listed above.
- This authorization is valid for one year from the signature date unless specified below:
  - ☐ Expires on _____ ☐ One time only ☐ Other (specify): _____
- This consent will no longer be valid once I am discharged from services except for a one-time notification to my Primary Health Care Provider to inform them that I am no longer receiving services with Easterseals MORC.
- It is the organization or person(s) listed above responsibility to obtain my authorization to redisclose the information. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 C.F.R. Part 2. This authorization also complies with all other applicable federal and state laws and regulations.
- Easterseals MORC does not release records received from a third party.
- Easterseals MORC is not required to use this authorization to coordinate treatment, ensure payment, or for healthcare operations.
- My services will continue even if I refuse to sign this authorization.

☐ Self ☐ Parent ☐ Guardian

PRINT NAME OF INDIVIDUAL SIGNING AUTHORIZATION — RELATIONSHIP TO INDIVIDUAL RECEIVING SERVICES

Individual/Parent/Guardian Signature _____ Date _____