AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

The Menninger Clinic
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Please read this entire form. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **COPIES WILL BE SUBJECT TO A REASONABLE FEE AS PROVIDED BY STATE LAW.**

I, _____, _____ DOB: _____ hereby freely and voluntarily authorize
Print Name **Patient ID #**

The Menninger Clinic to: *(check only one option)*

☒ Release/Disclose printed information to ☐ Obtain written information from ☐ Exchange Verbal Communication with

RECORDS DEPOSITION SERVICE, INC.
Name or Organization

P.O. BOX 5054 — 248-357-3330
Address — **Phone Number**

SOUTHFIELD, MI, 48086-5054 — 248-357-3337
City, State, Zip Code — **FAX Number**

1. The information is needed for: *(check at least one option)*:

☐ Treatment ☐ Disability ☐ Billing/Claims ☒ Legal ☐ Other:_____

2. Method of delivery: (*check only one option*): ☐ Mail ☐ Fax

3. Information to be released or accessed: I specifically authorize either (depending on my selection above) (1) the release or disclosure or (2) verbal communication regarding the following **designated** protected health information (PHI) and / or records, if such information and / or records exist from _____ to _____
Date **Date**

- ☐ Discharge Summary
- ☐ Neuropsychological Testing
- ☐ Eating Disorder Assessment
- ☐ HIV/AIDS Test Results / Information
- ☐ Psychiatric Evaluation/Assessment (excluding psychotherapy notes and substance abuse records)
- ☐ Psychological Testing
- ☐ Treatment Plan
- ☐ Genetic Information
- ☐ Psychosocial Assessment
- ☐ All health information (excluding psychotherapy notes and substance abuse records)
- ☐ Billing Information
- ☐ Physician Orders
- ☐ Laboratory Reports
- ☐ History and Physical
- ☐ Other _____

4. Substance Use Disorder Information: (Optional) By initialing below, I explicitly authorize in accordance with 42 C.F.R. Part 2 the release/disclosure of alcohol, drug, and substance abuse information if present in my protected health information, including, if present, diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summaries, employment information, living situation and social supports, and claims and encounter data. I understand that if I do not authorize disclosure of alcohol, drug, and substance abuse information, much or all of my protected health information may not be released.

_____ I authorize disclosure of all of my substance use disorder information.

5. Effective time period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) _____.

6. Right to revoke: I understand that I can withdraw my permission at any time by giving written notice by certified mail stating my intent to revoke this authorization to the person or organization named above and to The Menninger Clinic. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

7. SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that my medical records may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology), or PSYCHIATRIC DISORDERS**. I understand that such information is confidential and is protected by federal law. I understand that refusing to sign this form does not stop disclosure of health information that already has occurred or that is otherwise permitted by law without my specific permission, including disclosures as provided by Texas Health & Safety Code § 181.154(c), 45 C.F.R. § 164.502(a)(1), and/or 45 C.F.R. 164.512(a). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient (unless re-disclosure is prohibited by law) and may no longer be protected by federal or state privacy laws. I understand that I may inspect or copy any information to be used or disclosed under this authorization.

_____ _____
Patient/Parent Signature (if patient is a minor) or Legal Authorized Representative **Date**

*A minor individual's signature is required for the release of certain types of information, including for example, the release of information relating to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse. Photo identification will be requested to verify your identity.

_____ _____
Minor's Signature **Date**