MICHIGAN DEPARTMENT OF CORRECTIONS – Bureau of Health Care Services

CHJ-121
4/11

PATIENT'S AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name:	Number:	D.O.B.
(PRINT OR TYPE FULL NAME OF PATIENT)		

Information to be released from:

Facility:	Address:

Information to be released to:

Name:	Address:	Organization (if applicable):
RECORDS DEPOSITION SERVICE, INC.	P.O. BOX 5054 SOUTHFIELD, MI 48086-5054	P: 248-357-3330 F: 248-357-3337

Information to be disclosed: MCL 333.26269 allows an initial fee of $20.00; $1.00 charge per page for the first 20 pages; $.50 charge per page for the next 20 through 50 pages; and $.20 charge per page for anything over 51 pages. Being specific about your request will reduce your costs of copying.

SPECIFIC DATES OF INFORMATION TO BE RELEASED: Beginning Date: Ending Date:

☐ Written **Written Information to be released up to the date of the signature.**

SPECIFIC INFORMATION: ☐ Medical ☐ Dental ☐ Mental Health ☐ Complete Health Record

☐ Verbal **Verbal authorization valid for 6 months beyond signature date.**

VERBAL RELEASE TO EXCLUDE: ☐ HIV/Hepatitis Status ☐ Mental Health ☐ Substance Abuse

Other – Specify: PLEASE SEE ATTACHED SUNPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

By signing this form I am attesting to the fact that the records I am requesting be released, including alcohol, drug abuse, mental status,[1] and serious infectious and communicable diseases (including venereal diseases, tuberculosis, Hepatitis C, and HIV infection)[2] are protected under State of Michigan and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation.

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above stated request. No information collected beyond this date will be released unless it pertains to this request. This request will automatically expire after six months from the date of signature.

I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I DO HEREBY CONSENT TO THE DISCLOSURE OF THE ABOVE DESCRIBED INFORMATION CONTAINED IN THE HEALTH RECORD IDENTIFIED ON THIS FORM.

Date:	PATIENT / MINOR'S PARENT / GUARDIAN / MEDICAL POWER OF ATTORNEY SIGNATURE
Date:	WITNESS SIGNATURE

1 Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose (21 USC 1175; 42 USC 4582).

2 Michigan Public Health Code (MCL 333.1101 et seq.): Medical Records Access Act (MCL 333.26261 et seq.).