Chippewa County Health Department

Authorization to Disclose and/or Obtain Protected Health Information

Individual's Name:	
Phone:	**Date of Birth:**
Address:	

***I give permission to Chippewa County Health Department*: To Release** and/or **Exchange** information and records from the following person and/or agency/group using **Verbal** and/or **Written** communication via telephone, fax, mail, or electronic transmission contained in the client record referenced above:

Person/Organization Name:	Street Address:
City, State, Zip:	Phone: / Fax:

Information to be released/obtained/exchanged includes:

☐ Information pertaining to treatment provided, results of clinical tests, referrals, and any summary of diagnosis, symptoms, functional status, treatment plan, prognosis, and progress to date.

☐ Only the following medical information specified by description and date: (List types of health information you want to share):_____
_____

All records pertaining to Mental Health/Psychological Testing, Chemical Dependency, HIV/AIDS services which may include HIV testing, and information related to treatment of sexually transmitted infections, tuberculosis, other communicable diseases as specified by the Michigan Department of Health and Human Services will not be released unless specifically authorized by signature below:

☐ Privileged and confidential behavioral health _____ *(Signature)* Date:_____

☐ Chemical dependency_____ *(Signature)* Date:_____

☐ HIV/AIDS_____ *(Signature)* Date:_____

☐ STI/TB/CD_____ (Signature) Date:_____

This information is protected by federal law (42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is INSUFFICIENT for the purpose.

The reason for this release or exchange of information is:

☐ Diagnosis & Treatment ☐ Coordination of Care ☐ Other:_____

By signing this Form, I understand that:

I am giving consent to share my information as indicated. My information may be shared between each department, agency, or person listed above. The sharing of my health information will follow state and federal laws and regulations. I can revoke (cancel) my consent at any time either verbally or in writing; however, any information shared with or in reliance upon my consent cannot be taken back. I can have a copy of this form. My consent will expire on the following date_____ (if expiration is left blank, the consent will expire one year from the signature date):

Signature of Individual or Legal Representative	Date
Printed Name of Individual or Legal Representative & relationship to the individual	