Traverse Health Clinic
1719 S. Garfield Avenue
Traverse City, MI 49686

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Traverse Health Clinic

Authorization to Release Health Information

Patient Name:		Birth Date:
Address:		
City:	State:	ZIP Code:

I authorize Traverse Health Clinic and its employed and contracted health professionals to release health information identifying me to the following persons or entities:

Name: _____

Address:_____

Phone: _____Fax: _____

I expressly waive all privileges that may be associated with my health information to be released. I acknowledge and understand that the health information about me to be released may contain the following types of information: alcohol and drug use treatment records protected under regulations at 42 Code of Federal Regulations, Part 2; mental health services records, including communications between me and a social worker, a licensed counselor or a psychologist; information about genetic testing; information about testing and treatment for sexually transmitted diseases, including Human immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC).

INDICATE EACH TYPE OF INFORMATION TO BE DISCLOSED:

___ Admission/Discharge Letters, Summaries
___ Behavioral Health Notes
___ Behavioral Health Treatment Plans
___ Primary Care Notes
___ Psychiatric Notes
___ Recovery Plan
___ Lab & X-Ray Reports
___ Entire Record w/Behavioral Health Information
___ Entire Record – Primary Care Information
___ Other Information (specify) _____

* **Psychotherapy Notes require a separate authorization**

The above types of released records are to cover the following dates of service:

_____ From _____/_____/_____ to _____/_____/_____; **OR,**

____ All past records of the types indicated above

_____ (**Check here if desired**) all records of the types indicated above created within 12 months **after** the date this authorization is signed, as requested.

PURPOSE/NEED FOR RECORD RELEASE:

___ Health Treatment/Services/Referral	___ Vocational Rehabilitation	___ Other (specify):
___ Disability/Benefit Determination	___ Return to Work	_____
___ Legal Matters	___ School Request	_____
___ Billing/Payment for Services	___ Social Service Referral	_____

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the information and entries made in my medical record if I need help understanding them. This will prevent my misunderstanding of the information that has been written in the record. I will not hold Traverse Health Clinic liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.

I understand that it is my decision whether or not to sign this authorization and Traverse Health Clinic may not refuse to treat me if I choose not to sign.

I have the right to revoke this authorization at any time, except to the extent that Traverse Health Clinic has already acted in reliance upon it. To revoke this authorization, send a written request for revocation to the Traverse Health Clinic Privacy Officer at the address listed above.

With the exception of substance use disorder treatment information, mental health information or HIV/AIDS/ARC information, the recipient named above may have no legal duty to further protect the confidentiality of your health information. In some cases, the recipient may re-disclose the information as he/she wishes.

This authorization is valid until the earlier of (insert date or event) _____ or (1) year from the date of signature, unless earlier revoked.

Authorizing Signature:	**Date:**
Print Name:	

If someone other than patient is signing, please explain his/her relationship to patient and source of authority to sign to this form:

If applicable, attach legal documents establishing source of authority to sign, such as guardianship papers or power of attorney.

The patient shall be provided with a copy of this signed authorization.