CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

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CONSENT TO RELEASE AND OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

I authorize **CMU Health Behavioral Medicine** to disclose and/or obtain the Protected Health Information (PHI) that I have identified below with my initials.

Information Requested:

_____Entire Record	_____Medication	_____Therapy Assessment
_____Demographic Information	_____Participation in Treatment	_____Treatment Plan
_____Diagnosis	_____Progress in Treatment	_____Other_____
_____Discharge/Transfer Summary	_____Psychiatric Evaluation	

Dates of Treatment: _____

Method of disclosure: _____ Phone _____ Fax _____ Mail _____ All

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, to share information relevant to treatment and, when appropriate, to coordinate treatment services. (If it is for another purpose, please specify.)

_____

Expiration: I understand that this release will automatically expire one year from the date of my signature below unless I specify a different date, event or condition of expiration as follows: _____

Revocation: I understand that I have a right to revoke this authorization at any time by: 1) Sending written notification to CMU Health Behavioral Medicine; 2) Giving verbal permission via telephone (CMU Health Behavioral Medicine will ask for specific identifying information from me); 3) Making an in-person request and signing and dating a Revocation Form. I further understand that a revocation is not effective to the extent that action has already been taken in reliance upon this authorization.

Information is to be released to _____and/or obtained from _____the following individual(s) or organization: (Please **INITIAL** one or both)

Name _____
Address _____City _____ State _____Zip Code _____
Fax Number _____Telephone Number _____

I understand that I am authorizing the release of information contained in my medical record which may include information about 1) Communicable diseases and infections such as Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC); 2) Substance abuse treatment records protected under Federal regulations [42 CFR, Part 2]; and 3) Mental health treatment records, psychological/psychiatric services and social service information including communication made by me to a social worker, licensed professional counselor, psychologist, or psychiatrist, if any, to the individuals or organizations listed below.

I hereby release CMU Health Behavioral Medicine and its staff from all legal responsibility that may arise from the release of the above information and/or these records. I understand that CMU Health Behavioral Medicine may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature _____ Date _____
Parent/Guardian Signature _____ Date _____
Witness Signature _____ Date _____