AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD
(Also known as Protected Health Information)

PATIENT NAME: _____ **Date of Birth:** _____

Address: _____ **Phone** _____

I, _____, authorize Shine Wellness Clinic to use or disclose information from my (or my child's) mental health records, which may include information about psychiatric diagnosis, treatment, and progress to:

Agency/School/Individual: _____

Name: _____ Address: _____
Phone: _____ FAX: _____ Email: _____

Dates of Treatment: Previous and Ongoing

Information to be released (Please describe) SHINE WELLNESS CLINIC services-Diagnosis, Treatment Plans, Progress Notes, Testing and Outcomes.

Purpose of Disclosure Case Coordination

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Shine Wellness Clinic at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at Shine Wellness Clinic will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that in compliance with Michigan general statute.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ and/OR _____

Signature of Patient & Date Parent/Legal Guardian/Authorized Person & Date