Comprehensive Integrative Health Care

30880 Beck Rd. Novi MI, 48377
Phone: 248-926-0009 Fax: 248-956-9198

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ herby authorize _____

_____ _____
Phone Number Fax Number

It's Dirceetor or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any: behavioral medicine services record, if any, including communications made by me to a social worker or psychologist, and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

1. Name of person(s) or organization(s), to whom disclosure is to be made:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by law.

2. Specific type of information to be disclosed:
The authorized person must intial next to the type of information to be disclosed.

_____ ER Report	Date of Service _____
_____ Intial Asssessment	Date of Service _____
_____ Medical Evaluation	Date of Service _____
_____ X-ray Report	Date of Service _____
_____ Laboratory Tests	Date of Service _____
_____ Operative Reports	Date of Service _____
_____ Psychiatric Evaluation	Date of Service _____
_____ Discharge Summary	Date of Service _____
_____ Information regarding _____	
_____ ***All Records***	

3. The Purpose and need for such disclosure:

_____ Employer request	_____ Disability Cert	_____ Continuation of Care	_____ Research
_____ Social Security	_____ Insurance Claim	_____ Consultation	_____ Personal Use
_____ Social Service	_____ Insurance Application	_____ School requirement	_____ Attorney Inq
_____ Worker's Comp	_____ Other (specify) _____		

4. This authorization can be revoked in writing, at any time except for that information which has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for release has been achieved. Integrated Health Care Associates uses a medical records transfer company whose rates are mandated by the State of Michigan and will usually not exceed more than $40.00.

Signature of Patient: _____

Date of Birth of Patient: _____ Patient #: _____

Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor:

Relationship: _____ Date: _____

Address: _____ Phone #: _____

Witness Signature: _____