Michigan Diversion Center
3253 Congress Ave. Saginaw, MI 48602
OFFICE (989) 308-1455 FAX (989) 393-6021

AUTHORIZED RELEASE OF INFORMATION

This authorization for release of information is in accordance with Section 748, Public Acts of 1974, as amended and follows Title 42 CFR, Part II and the requirements for security and privacy under the Health Insurance Portability and Accountability Act 45 CFR, Part 160 and Part 164. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, my payment or my eligibility for benefits. I understand that information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the federal privacy regulations. See revocation rights below:

I, _____ ☐ **AUTHORIZE** ☐ **DECLINE**: Michigan Diversion Center to

(**Client, Parent, Guardian, or Personal Representative**)

☐ **RELEASE/DISCLOSE and/or** ☐ **OBTAIN** the personal health information described below **to and from**:

_____ **Pertaining to Client**

Name of Person/Agency

Name: _____

_____

Address DOB: _____

_____

City State Zip

INFORMATION TO BE RELEASED, DISCLOSED, & OBTAINED BY MCDOWELL HEALING ARTS CENTER:

I understand that I may limit, restrict and/or specifically define the information to be disclosed. I understand that I may revoke or rescind this authorization for release by notifying my Case Manager, Therapist or designee in writing at any time. I understand that if I revoke this authorization it will not have any effect on actions taken by MCDOWELL HEALING ARTS CENTER in reliance on it before it was revoked.

RELEASE & DISCLOSE	OBTAIN
_____ All records including verbal &/or written	_____ All records including verbal & written
_____ Assessment	_____ Assessment
_____ Demographic Information	_____ Demographic Information
_____ Diagnosis	_____ Diagnosis
_____ Discharge/Transfer Information	_____ Discharge/Transfer Information
_____ Other: _____	_____ Other: _____
_____ Presence/Participation in Treatment	_____ Presence/Participation in Treatment
_____ Progress in Treatment	_____ Progress in Treatment
_____ Progress Notes	_____ Progress Notes
_____ Treatment Plan or Summary communications	_____ School Records
_____ Excluding: _____	_____ Treatment Plan or Summary communications
	_____ Excluding: _____

Purpose of this Disclosure: ***To assist with the coordination of services between clinic and the above-named person or entity*** and/or for the following purposes: ☐ Consultation ☐ Evaluation of Academic concern ☐ Personal Use

☐ Parent/Partner Consult ☐ Insurance ☐ Other: _____

I understand that this authorization will expire one year from the date that I indicate below alongside my signature or by my notice of revocation, or on the happening of the event of completion of treatment.

Client Name: _____ Address: _____

Signature of Client _____ Date: _____

Signature of Witness/Office Staff: _____ Date: _____