ADVANCED BEHAVIORAL MEDICINE, PC

I AUTHORIZE ADVANCED BEHAVIORAL MEDICINE (ABM), ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT WHICH MAY INCLUDE ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV OR AIDS OR ARC; COMMUNICABLE DISEASE OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASE, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES, AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

Completion of this document authorizes the disclosure and/or use of the individually identifiable health information, consistent with applicable State and Federal law. **Failure to provide *all* information requested may invalidate this Authorization.**

1. Protected health information may be used or disclosed regarding the following patient.

NAME: (Last) _____ (First) _____ (M.I.) _____

DATE OF BIRTH - _____ **S.S. # -** _____ (optional)

ADDRESS: (Street) _____ (City) _____ (State) _____ (Zip) _____

TELEPHONE: (day) (_____) _____ (evening) (_____) _____

2. _____ is authorized to make the requested use or disclosure of my health information.
(Facility to **RELEASE** information)

ADDRESS: (Street) _____ (City) _____ (State) _____ (Zip) _____

PHONE: (_____) _____ **FAX:** (_____) _____ **EMAIL:** _____

3. _____ is authorized to receive my Protected Health Information.
(Facility to **RECEIVE** information)

ADDRESS: (Street) _____ (City) _____ (State) _____ (Zip) _____
PHONE: (_____) _____ **FAX:** (_____) _____ **EMAIL:** _____

I AUTHORIZE MY INFORMATION TO BE FAXED TO THE ABOVE RECIPIENT. _____
(Patient, Parent, or Legal Representative Signature)

INFORMATION TO BE RELEASED:

- ☐ Psychiatric Evaluation: From _____
- ☐ Clinical Assessment: From _____
- ☐ Progress Notes: From _____ to _____
- ☐ Medication History: From _____ to _____
- ☐ Laboratory Tests/Results: From _____ to _____
- ☐ **All of the Above Information**
- ☐ Billing information: From _____ to _____
- ☐ **OTHER** (specific): _____

PURPOSE FOR RELEASING INFORMATION:

- ☐ At the Request of the Patient
- ☐ Continuation of Care/Consultation
- ☐ Social Security/Disability Certification
- ☐ Attorney Inquiry/Legal Matter
- ☐ Insurance Claim/Application
- ☐ Worker's Compensation
- ☐ **OTHER** (specify): _____
- ☐ Phone Contact Only - **(COPIES WILL NOT BE SENT)**

Date Authorization expires: _____ (may be a specific date or a condition; if no expiration date or condition is listed, this release will expire 6 months from date signed)

SIGNATURE: _____ **DATE:** _____
(Patient, Parent, or Legal Representative)

SIGNATURE: _____ **DATE:** _____
(Witness)

REVOCATION: I understand that I may revoke my authorization by writing to; Advanced Behavioral Medicine, 2901 E. Grand River, Howell, MI 48843. After it is revoked, ABM will make no further disclosures to the above persons without a new authorization. ABM can rely on this authorization until it is revoked, or until the expiration date or conditions are met. A request to revoke my authorization will not apply to the extent ABM has taken action in reliance upon my authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the revocation will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself. **REDISCLOSURE:** Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **CONDITIONING OF ELIGIBILITY:** ABM will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.

2901 E. Grand River Howell MI 48843 **517-548-1537 Fax 517-548-9399**