



# Community Hope Christian Counseling

*Helping People Find the Hope of Christ*

## AUTHORIZATION FOR RELEASE AND DISCLOSURE, AND/OR REQUEST FOR MEDICAL INFORMATION RECORDS

I, \_\_\_\_\_ (patient), (\_\_\_\_/\_\_\_\_/\_\_\_\_ date of birth) authorize  
Community Hope Christian Counseling to: (✓ one or both below)

release information from my records to the individual or organization to be listed  
below.  request information from the individual or organization to be listed below

Name: \_\_\_\_\_

Address: \_\_\_\_\_

For the purpose of, use, or need: \_\_\_\_\_

The following information from my psychiatric/medical records may be disclosed within the  
dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_:

- Treatment Summary
- Physical Examination
- Diagnosis
- Psychiatric Evaluation
- Laboratory Studies
- Treatment Plan
- Initial Assessment
- Current Treatment Update
- Progress in Treatment
- Progress Notes
- Entire Chart
- Other
- Exclude the following Information: \_\_\_\_\_

Release Status:     Active  Expired     Invalid     Revoked

Verified By: \_\_\_\_\_

- I understand there is a possibility the protected health information may be re-disclosed by the recipient of the information and will no longer be protected by Privacy Rules.
- I understand treatment, payment, enrollment, and/or eligibility for services will not be conditioned upon signing of this authorization.
- I understand this authorization will be honored unless revoked by me verbally or in writing. Revocation may be made at any time except to the extent that the action has been taken. To revoke an authorization, I need to notify the administrative office of Community Hope Christian Counseling or my treating clinician.
- I understand this authorization will expire **ONE YEAR from the date of my signature or until:\_\_\_/\_\_\_/\_\_\_**

**Note to Recipient of Disclosed Mental Health Information:** This disclosed information is protected by the Mental Health Code 330.1748. Individuals receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

**Note to Recipient of Disclosed Substance/ Alcohol Abuse Information:** The information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patent. {52 FR 21809, June 9, 1987; 52 FR 41997, Nov 2, 1987}

I understand that my alcohol and/or drug treatment records are protected under the Federal confidentiality rules (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR Parts 160 &164. Information about my mental health status is confidential and is protected by the Michigan Mental Health Code PA 258 of 1974, section 78 (3), PA 488 of 1988, effective 3/30/1989 – 42 CFR 455, Part B. Information about my medical condition, including status of serious communicable disease or infections such as HIV and acquired immunodeficiency syndrome (AIDS), is confidential and protected under the Michigan Public Mental Health Code PA 368. This information cannot be disclosed without my written consent unless otherwise provided for in the regulations.

**Signed by:**

**Staff:**\_\_\_\_\_

**Date:**\_\_\_/\_\_\_/\_\_\_

**Printed Name**\_\_\_\_\_

**Client/Consumer:**\_\_\_\_\_

**Date:**\_\_\_/\_\_\_/\_\_\_

**Printed Name:**\_\_\_\_\_

**Parent/Legal Guardian:**\_\_\_\_\_

**Date:**\_\_\_/\_\_\_/\_\_\_

**Printed Name:**\_\_\_\_\_

**Relationship:**\_\_\_\_\_

**Witness:**\_\_\_\_\_

**Date:**\_\_\_/\_\_\_/\_\_\_

**Printed Name:**\_\_\_\_\_

6728 Vining Rd, Greenville, MI 48838 Ph. 616-225-8220 Fx. 616-225-8226