INSIGHT BEHAVIORAL WELLNESS OF NORTHERN MICHIGAN LLC

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REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I, _____, born on _____, authorize _____
Patient name (print) Clinician Name

_____ To Release/Disclose To: **_____ To Obtain Information From:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This information is for treatment planning and ongoing care. If for other reason, please describe:

This authorization includes release of records relating to:

_____ Mental Health
_____ Chemical Dependency Abuse Treatment
_____ HIV/AIDS
_____ Diagnoses and/or treatment relating to other communicable diseases

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations. I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may request a signed copy of this form. I have been informed that I may revoke this consent – **in writing** – should I decide to do so and the revocation is effective the date my request is received by my clinician. This consent will expire automatically upon termination of care or as of _____.

_____ _____ _____
Signature of Patient or Parent/Guardian Date Relationship to Patient

_____ _____ _____
Signature of Witness Date Identification Verified
(staff use only)