HURLEY MENTAL HEALTH ASSOCIATES
Authorization for Release of Information
1085 S. Linden Road, Suite 150
Flint, Michigan 48532

Patient Name: _____Date of Birth: _____ SS: _____
Address: _____City: _____ Zip: _____

I authorize the use or disclosure of the above named individual's protected health information between ***HURLEY MENTAL HEALTH ASSOCIATES*** *and _____ Address: _____* ***as described below:***

1. *The type and amount of information to be used or disclosed is as follows: _____*
_____
_____
_____

2. *This information pertains to the services that were provided to:*
   Name of Patient (if different from above): _____

3. *This information may be disclosed to, and used by the above organizations for the following purpose:* ***(the individual authorizing release of information may write "at the request of the individual" if the individual elects not to provide a statement of purpose.***
   _____
   _____

4. *I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.*

5. *I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the individual in charge of my treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:*
   _____
   If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. *I understand that authorizing the disclosure of this information is voluntary. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.*

_____ _____
Date *Patient's Signature*

_____ _____
Witness Signature *Parent or Guardian's Signature if Required*
Revised 8-5-10