MOTT CHILDREN'S HEALTH CENTER (MCHC)
Authorization to Release PHI
806 Tuuri Place, Flint, MI 48503
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name: _____ **Birth Date:** _____

1. By signing below, I hereby authorize my child's, (my) Protected Health Information as more specifically described below, to be used or disclosed:
2. Specific type of information to be used/disclosed: [Including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; social services records, if any; and psychological services records, if any, including communications made by me to a social worker or psychologist; or any records pertaining to HIV infection, acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or a test for any such disease, including records protected under ACT 488, Public Acts of Michigan, 1988], if any to the individuals or organizations listed below, only under the conditions listed below.

☐ Health Records	☐ Substance Abuse Treatment/History
☐ Dental Records	☐ School & Academic Records/Special Education
☐ Mental Health Evaluation/Treatment	☐ Educational Testing
☐ Psychiatric Treatment History	☐ Court Records
☐ Psychosocial Evaluation/Family/Placement History	☐ Other _____

3. The specific person or classes of persons who are authorized to use or disclose my Protected Health Information are as follows:
   ☐ MCHC Entire Workforce ☐ other agency / agencies workforce.

   MCHC
   Attn: ☐ Medical ☐ Dental ☐ Mental Health
   806 Tuuri Place
   Flint, MI 48503

   Name: _____
   Agency: _____
   Address: _____

   Individuals receiving information made confidential by Section 748 Act 258 of the Mental Health Code shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

4. The purpose and need for such disclosure and how the information to be disclosed is germane to the purpose.

☐ Is at my request	☐ Treatment Planning	☐ Referral Recommendations
☐ Intake/Assessment Planning	☐ Service Coordination	☐ Other_____
☐ Educational Assessment Plan	☐ Treatment Progress/Recommendations	

5. I understand that Mott Children's Health Center will not condition treatment, payment, enrollment in MCHC services or eligibility for benefits on the provision of this Authorization.
6. I understand that I may refuse to sign this Authorization.
7. This authorization shall expire one year from date of signature.
8. I understand that I have the right to revoke this authorization, if the revocation is in writing to the MCHC Privacy Officer, 806 Tuuri Place, Flint, MI 48503. Except if
   - Mott Children's Health Center has taken action in reliance upon this authorization;
   - or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
9. I understand that I may revoke this Authorization by contacting the MCHC, Privacy Officer, 806 Tuuri Place, Flint, MI 48503
10. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.
11. I understand that the use or disclosure of my Protected Health Information By Mott Children's Health Center will result in direct or indirect remuneration to Mott Children's Health Center from a third party, as follows:
    Compensation for the cost of compiling and sending the information to be disclosed.

By signing this authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

_____
Signature (Client/Parent or Guardian) Date

_____
Signature (Witness) Date

Relationship of Client/Parent or Guardian's authority to sign for the patient: _____

To Be Used For All
Department Uses or Disclosures

Copy to Client
Original in Chart