

**AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION**

I, \_\_\_\_\_, **DOB:** \_\_\_\_\_ hereby authorize **BRIGHTON HOSPITAL**, its Director, Designee or Medical Record Department, to:  
**[Initial only ONE of the following choices:]** **RELEASE**  or **OBTAIN** \_\_\_\_\_ or **EXCHANGE** \_\_\_\_\_ information contained in my health records, including alcohol and drug abuse records protected under 42 Code of Federal Regulations, Part 2, if any; psychological services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to the individual/organization listed below, under the conditions listed below:

**1. Name of person or organization, to whom disclosure is to be made:**

Name: MINUTE MAN SERVICES, INC. Organization: \_\_\_\_\_  
 Street Address: 3318 N MAIN Relationship: \_\_\_\_\_  
 City: ROYAL OAK State: MI Zip Code: 48073  
 Phone: 248-585-6300 Fax: 248-585-5822 Other: \_\_\_\_\_

I understand that my protected health information (PHI) disclosed under this authorization may be re-disclosed by the individual or organization named above and its privacy may no longer be protected by law.

**2. Specific type of information to be disclosed:**

**[Initial all types of information that apply to person/organization listed above.]**

- |   |   |
|---|---|
| <input type="checkbox"/> Admission Assessment                     | <input type="checkbox"/> Emergency Contact                                    |
| <input type="checkbox"/> Aftercare Plan                           | <input type="checkbox"/> Financial/Insurance Information                      |
| <input type="checkbox"/> Acceptance of Special Deliveries         | <input type="checkbox"/> Nursing Assessment                                   |
| <input type="checkbox"/> Admission/Discharge Letter               | <input type="checkbox"/> History & Physical                                   |
| <input type="checkbox"/> AMA Alert                                | <input type="checkbox"/> Progress Notes                                       |
| <input type="checkbox"/> Bio-psychosocial Evaluation              | <input type="checkbox"/> Psychiatric Evaluations                              |
| <input type="checkbox"/> Completion of Benefit Forms              | <input type="checkbox"/> Psychiatric Medication Reviews                       |
| <input type="checkbox"/> Dates of Treatment/Completion of Program | <input type="checkbox"/> Treatment Plans                                      |
| <input type="checkbox"/> Discharge Summary                        | <input type="checkbox"/> TB Test Results <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Other _____                              | <input type="checkbox"/> Urine Drug Screen                                    |

**3. Purpose and need for such disclosure:**

**[Initial all that purposes and need that apply to person/organization listed above.]**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Aftercare Planning    | <input type="checkbox"/> Emergency                      | <input type="checkbox"/> Other Time Off Benefits  |
| <input type="checkbox"/> Attorney              | <input type="checkbox"/> Employer Request/Job Stability | <input type="checkbox"/> Parole/Probation Officer |
| <input type="checkbox"/> Continuity of Care    | <input type="checkbox"/> Drivers License Appeal         | <input type="checkbox"/> Payment of Bill          |
| <input type="checkbox"/> Court                 | <input type="checkbox"/> Family Involvement/Therapy     | <input type="checkbox"/> School                   |
| <input type="checkbox"/> Disability Benefits   | <input type="checkbox"/> Guardianship                   | <input type="checkbox"/> Social Security Benefits |
| <input type="checkbox"/> Other - Specify _____ | <input type="checkbox"/> Worker's Compensation          |   |

**4. Revocation of Authorization:** This authorization may be revoked by me at any time, except in legal action cases, by my written notice to the above named individual or organization, except to the extent that the person or organization that is to make the disclosure has already taken action in reliance on my authorization.

**5.** If not previously revoked by me in writing, this authorization is effective on this date and will expire 6 months following discharge from treatment.

**6.** I have been informed of the above checked areas and I understand what information is going to be released to the above named individual or organization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by

\_\_\_\_\_  
Date