Three Mountains Wellness, LLC

1780 E. Grand River, East Lansing, MI 48823

(517) 763-1497 Fax: (734) 272-4235

Authorization to Use and Disclose Health Care Information

Patient's Name: _____ Birth Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize and request Three Mountains Wellness, LLC to use or make a disclosure of my protected health information, including all information protected under the regulations in Title 42 of the Code of Federal Regulations, Part II, including:

☐ Alcohol and drug abuse ☐ Treatment for mental health symptoms

☐ Treatment for symptoms related to AIDS, AIDS-related disorders and/or HIV.

Person or organization authorized to receive information:

Receiving party or agency: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Specific type of information to be used or disclosed: Dates of Service: _____

☐ Initial evaluation ☐ Treatment notes ☐ Entire record

☐ Consultation reports from (doctor's name): _____

☐ Verbal discussion of case ☐ Letter for patient

This information may be used and disclosed for the following purposes:

☐ Patient Use ☐ Insurance ☐ Attorney/Court/Legal Use ☐ Disability Claims

☐ Other: _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

I understand that if the person or entity that received the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.

I understand that I may revoke this authorization at any time by notifying Three Mountains Wellness, LLC in writing. However the revocation will not be valid if Three Mountains Wellness, LLC has taken action in reliance on this authorization.

This authorization expires on (date or event) _____ or 90 days from the signature below.

_____
Patient Name (printed)

_____ _____ _____
Signature of Patient or Patient's Representative Date

If using a Personal Representative:

Print Name of Personal Representative: _____

Relationship of Personal Representative: ☐ Parent of minor child ☐ Legal Guardian ☐ Power of Attorney

☐ Other: _____

Please attach proof of your relationship to the patient *(ex: Power of Attorney, personal representative documentation).*

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations which prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FURTHER DISCLOSURE OF THIS INFORMATION IS PROHIBITED UNLESS OTHERWISE PERMITTED BY FEDERAL AND STATE LAWS. (P.A. 258 of 1974. Section 748(3); P.A.368 of 1978; 42 CFR Parts 160 and 164 (HIPPA); P.A. Act 488 of 1989)