ADVANCED COUNSELING SERVICES, P.C.
Authorization for Use and Disclosure of Information

I,_____, authorize, _____
to use or disclose the following protected health information: (*Specifically describe information to be used) **Progress notes are afforded special protection under the Health Insurance Portability and Accountability Act of 1996 and are not to be released***

_____Clinical Record: Including Assessment, Treatment Plan, Status Reviews, Psychiatric Evaluation, Medication Reviews, Re-Admission, and Discharge Summary.

_____Other:_____

_____

This release allows Advanced Counseling Services, P.C. or its designee, or the individual or organization's Administrator or designee, to release information contained in my records, including mental health records protected by Michigan Public Act 290 of 1996 (the Mental Health Code), if any, and alcohol and drug abuse records protected by Code 42 of Federal Regulations, Part 2 and protected health information protected by the Health Insurance Portability and Accountability Act of 1996. This includes medical services records, psychological/mental health services records, communications made to me by a physician, psychologist, social worker, or other health care provider; and information regarding communicable disease and infections which, as defined by Michigan Department of Community Health Rules, include venereal disease, tuberculosis, hepatitis B, Human immunodeficiency virus, and acquired immunodeficiency syndrome.

The protected health information may be disclosed to: (please include address and fax number).

_____

_____This is
_____Is not a reciprocal release of information.

This authorization shall be in force and effect for:

_____Until discharge from program _____90 days
_____Other (date should allow at least 30 days for processing of medical record requests)

Date: _____

At which time this authorization to use or disclose protected health information expires. * I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Advanced Counseling Services Privacy Officer.

* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

* I understand that the practice will not condition my treatment on whether I provide authorization for the requested use or disclosure.

* I understand I have the right to:

Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access to rights). Refuse to sign this authorization

_____

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative: _____

Patient's Date of Birth: _____

_____

Signature of Witness Date

Description of Personal Representative's Authority (if applicable): _____