PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Between: _____
_____
_____

Patient: _____
DOB: _____
SS# _____

And: Psychiatric Associates of West Michigan, P.L.C.
1403 60th Street SE
Kentwood, MI 49508
(616) 719-4488
Fax: (616) 719-4480

I, _____ (patient) give my permission to the above named to obtain __ and/or release __ by means of verbal, written, photocopy, or fax, certain confidential information about my psychiatric and/or medical treatment. This information may contain and/or treatment for HIV, infection and/or AIDS virus, and treatment recommendations under the provisions of P.A. 258 of 1974 as amended, Section 748, Subsection 5.

Information and/or Material to be released:

_____ Medical treatment record
_____ Phone Notes
_____ Psychotherapy notes
_____ Entire record (excludes therapy notes)
_____ Other:physician/hospital records
_____ Prescription copies

Purpose of disclosure:

_____ Continuation of care/discharge planning
_____ Coordination of Treatment Services
_____ Personal Use
_____ Transfer of care
_____ Other: _____

I am also aware of all consequences that might occur as a result of signing this consent form or of my refusal to do so. My signature means that I have read this form and/or have had it read to me and explained in a language I can understand. All the blank spaces have been filled in except for signatures and dates.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to Psychiatric Associates of West Michigan, P.L.C. at the above address.

Expirations or termination of authorization – This authorization will expire at the end of the calendar year in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): _____

Redisclocure – We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Psychiatric Associates of West Michigan, P.L.C.

Non-conditioning Statement – If the patient does not consent to this release, his/her treatment will not be compromised in any way.

A true and exact photostatic/faxed copy of this authorization shall have the same effect as the original.

_____

(Patient Signature or "X") (Date Signed) (Witness)

_____

(Patient's Guardian) (Date Signed) (Witness)