

PSYCHIATRIC ASSOCIATES OF WEST MICHIGAN, PLC
TWO WAY AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Between: _____ And: Psychiatric Associates
1403 60th Street SE
Kentwood, MI 49508
(616) 719-4488
Patient: _____ Fax: (616) 719-4480
DOB: _____
SS# _____

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:

Complete treatment record _____ Other: _____

Purpose of disclosure:

_____ Continuation of care/discharge planning _____ Insurance Billing Purposes
_____ Coordination of Treatment Services _____ Personal Use _____ 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
1403 60th St. SE
Kentwood, MI 49508
Attn: Privacy Manager

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): _____

Redisclosure – 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.

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)