HENRY FORD HEALTH.

Henry Ford Behavioral Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

(Patient Name)		
ereby authorize Records Department, to release information cont code of Federal Regulations, Part 2, if any; psych or psychologist; and any information regarding co enereal disease, tuberculosis, HIV, AIDS, and AF	hological services record, if any, including comn communicable diseases and infections as define	nunications made by me to a social worker ad by MCLA 333.5131, if any, which includes
. Name or person or organization, to whom	- · · · · · · · · · · · · · · · · · · ·	•
Name:		
Street Address:		
	State: Zip Co	odo:
Phone:	•	
understand that my protected health informat		a subject to redical cours by the individual
r organization named above and its privacy w		subject to redisclosure by the individual
. Specific type of information to be disclose	ed:	
The authorizing person must place the	heir initials next to the type of information to	be disclosed:
Diagnosis	Drug/Alcohol History***	Treatment Summary
Attendance	Mental Status Exam	Treatment Progress
Prognosis	Physical Examination	Discharge Summary
Medication Review	Intake/Assessment	Psychiatric Evaluation
Emergency Only	School Records - Specify:_	
Emergency Only Other – Specify: This information has been disclosed to you alles prohibit you from making any further disclosed.	from records protected by Federal Confidential losure of this information unless further disclosure of the confidence of	ality rules (42CFR Part 2). The Federal
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Behavorial Health PHI Authorization

