

CONSENT TO DISCLOSURE CONFIDENTIAL INFORMATION

PATIENT: _____ **BIRTHDATE:** ____ / ____ / ____

I hereby authorize _____ and/or Psychological Medicine to obtain information, and/or release information contained in my patient records, including alcohol and drug abuse records protected by the Federal Regulation 42, Part 2, if any; psychiatric service record, if any; child/adult abuse records, if any; social service records; if any; and information regarding any emotional illness communicated to me by a social worker or psychologist; from/to the organizations or persons listed below and only under the conditions listed below:

Name of Person/Organization to whom disclosure is to be made: _____

SPECIFIC INFORMATION TO BE DISCLOSED

DATES: _____

- | | |
|--|---|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> TREATMENT PLAN & REVIEWS |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> MEDICATION RECORDS |
| <input type="checkbox"/> PSYCHIATRIC EVALUATION | <input type="checkbox"/> NEUROLOGICAL STUDIES (EEG etc) |
| <input type="checkbox"/> HISTORY AND PHYSICAL EXAM | <input type="checkbox"/> LABORATORY REPORTS |
| <input type="checkbox"/> OT/PT ASSESSMENT | <input type="checkbox"/> X-RAY REPORTS |
| <input type="checkbox"/> SOCIAL HISTORY | <input type="checkbox"/> EMERGENCY ROOM REPORT |
| <input type="checkbox"/> PSYCHOLOGICAL REPORT | <input type="checkbox"/> EKG REPORT |
| <input type="checkbox"/> DAY TO DAY PROGRESS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> COMPLETE MEDICAL RECORD | <input type="checkbox"/> HIV, AIDS, AND ARC RECORDS |

PURPOSE AND NEED FOR DISCLOSURE

- | | |
|---|---|
| <input type="checkbox"/> CONTINUATION OF CARE | <input type="checkbox"/> DISABILITY DETERMINATION |
| <input type="checkbox"/> VOCATIONAL REHABILITATION | <input type="checkbox"/> SOCIAL SERVICE REFERRAL |
| <input type="checkbox"/> INSURANCE/BILLING VERIFICATION | <input type="checkbox"/> LEGAL FOLLOW-UP |
| <input type="checkbox"/> APPROPRIATE DISCHARGE PLANNING | <input type="checkbox"/> PERSONAL USE |
| <input type="checkbox"/> FAMILY SUPPORT AND EDUCATION | <input type="checkbox"/> OTHER: _____ |

This authorization will expire in six months from the date of the signature below. Providing a written statement from the patient may revoke the consent. This revocation will become effective when it is received by the facility. I understand that once the information described above has been disclosed, it may no longer be subject to the privacy protections afforded by Allegan General Hospital Psychological Medicine if the recipient of the information is not a health plan, health care provider, health care clearinghouse or a business associate that has a contract with Allegan General Hospital Psychological Medicine.

SIGNATURE OF WITNESS

SIGNATURE OF PATIENT

DATE WITNESSED _____

DATE SIGNED _____

IF APPLICABLE

REASON PATIENT IS UNABLE TO SIGN: _____

AUTHORIZED PERSON SIGNATURE
RELATIONSHIP TO PATIENT _____

SIGNATURE OF WITNESS
DATE SIGNED _____