

Recovery Pathways, LLC

Limited Patient Authorization to Disclose/Obtain Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name:

SSN (last four digits):

Date of Birth:

Entity Requested to Release/Obtain Information:

Essexville Office
863 N. Pine Rd. Ste. A
Essexville, MI 48732
Phone 989-928-3566
Fax 989-391-9596

Corunna Office
115 N. Shiawassee St.
Corunna, MI 48817
Phone: 989-494-0404
Fax: 989-494-0405

Ortonville Office
380 Mill St.
Ortonville, MI 48462
Phone: 248-961-3088
Fax: 248-627-7685

Midland Office
218 Fast Ice Dr.
Midland, MI 48642
Phone: 989-928-3566
Fax: 989-391-9596

Gladwin Office
655 E. Cedar Ave.
Gladwin, MI 48624
Phone: 989-928-3566
Fax: 989-391-9596

Isabella Office
301 S. Crapo St. Ste. 200
Mt. Pleasant, MI 48858
Phone: 989-928-3566
Fax: 989-391-9596

I authorize the entity identified above to perform the following with my protected health information to/from the individual(s) listed below.

Release to Obtain from

Who will be authorized to release/obtain information to/from Recovery Pathways, LLC (list the individual/entity who is to release/obtain your PHI):

Individual/Entity Name:

Address:

Phone: _____ Fax: _____

Description of information to be disclosed - I authorize the practice to disclose/obtain the following protected health information about me to/from the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

- | | |
|---|---|
| office notes | nursing home, home health, hospice, and other physician records |
| lab results, pathology reports | record of HIV and communicable disease testing |
| x-rays | record of mental health or substance abuse treatment |
| financial history report (previous 3 years only). | only send the following: _____ |

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request Other (please specify): _____

- This authorization will expire at the end of the calendar year of your signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- You have the right to receive a copy of signed authorizations upon request.
- 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 may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Client/Patient Parent of Minor Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Notice to Recipient:

This information has been disclosed to you from records is protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent from the person to whom it pertains or as otherwise permitted

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by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.