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	Corunna Office	Ortonville Office
863 N. Pine Rd. Ste. A	115 N. Shiawassee St.	380 Mill St.
Essexville, MI 48732	Corunna, MI 48817	Ortonville, MI 48462
Phone 989-928-3566	Phone: 989-494-0404	Phone: 248-961-3088
Fax 989-391-9596	Fax: 989-494-0405	Fax: 248-627-7685
Midland Office	**Gladwin Office**	**Isabella Office**
218 Fast Ice Dr.	655 E. Cedar Ave.	301 S. Crapo St. Ste. 200
Midland, MI 48642	Gladwin, MI 48624	Mt. Pleasant, MI 48858
Phone: 989-928-3566	Phone: 989-928-3566	Phone: 989-928-3566
Fax: 989-391-9596	Fax: 989-391-9596	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
- ☐lab results, pathology reports
- ☐x-rays
- ☐financial history report (previous 3 years only).
- ☐nursing home, home health, hospice, and other physician records
- ☐record of HIV and communicable disease testing
- ☐record of mental health or substance abuse treatment
- ☐ only send the following: Most Recent: Physical exam, lab work, medication list

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 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.