Myrtle C. Means, Ph.D.

Authorization for Use and Disclosure of Information

I, _____, hereby authorize Myrtle C. Means, Ph.D. to use or disclose the following protected health information: *(Specifically describe information to be used)**Progress notes are afforded special protection under the Health Insurance Portability and Accountability Act of* 1996 *and are not to be released***

_____

_____

_____

For the purpose of: _____

This release allows Myrtle C. Means, Ph .D, P.c. or its designee, or the individual or organization's Administrator or designee, to release information contained in my records, including mental health records protected by Michigan Public Act 290 of 1996 (the' Mental Health Code), if any, and alcohol and drug abuse records protected by Code 42 of Federal Regulations, Part 2 and protected health information protected by the Health Insurance Portability and Accountability Act of 1996. This includes medical services records, psychological/mental health services records, communications made to me by a physician, psychologist, social worker, or other health care provider; and information regarding communicable diseases and infections which, as defined by Michigan Department of Community-Health Rules, include venereal disease, tuberculosis, hepatitis B, Human immunodeficiency virus, and acquired immunodeficiency syndrome.

The protected health information may be disclosed to:
Name/address/phone/fax_____

_____

_____

This is_____ is not_____ a reciprocal release of information.
This authorization shall be in force and effect until the termination of treatment or
Date: _____

At which time this authorization to use or disclose protected health information expires.

*I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the psychologist.

*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that the practice will not condition my treatment on whether I provide authorization for the requested **use or** disclosure,

*I understand I have the right to:

Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access to rights).

Refuse to sign this authorization

_____

Signature of Patient or Personal Representative | Date | Social Security #

_____

Print name of Patient or Personal Representative | Date | Relation to Patient

_____

Signature of Witness | Date