MICHIGAN HEAD•PAIN & NEUROLOGICAL INSTITUTE
3120 Professional Drive • Ann Arbor, MI 48104-5131
(734) 677-6000 • FAX (734) 677-2422

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION FROM OR TO MICHIGAN HEAD•PAIN & NEUROLOGICAL INSTITUTE (MHNI)

Patient's Name _____ Patient's Date of Birth _____

Patient's Street Address _____ Social Security Number _____

City, State, Zip Code _____ Telephone Number _____

RELEASE OF MHNI INFORMATION

☐ I authorize Michigan Head•Pain & Neurological Institute (MHNI) to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, behavioral medicine services records, including communications made by me to a psychologist or other practitioner, to the individuals or organizations listed below, only under the conditions listed below. I understand that MHNI may charge me for this service as outlined in the attached letter.

Name(s) of person or organization to whom disclosure is to be made

Address

City, State, Zip Code

Phone Number, FAX Number

IF REQUESTING MHNI INFORMATION, RETURN THIS FORM TO:
Michigan Head•Pain & Neurological Institute
Medical Records Department
3120 Professional Drive
Ann Arbor, MI 48104-5131

TO HAVE INFORMATION SENT TO MHNI

☐ I authorize

Name(s) of person or organization whom will make disclosure

to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, behavioral medicine services records, including communications made by me to a social worker, psychologist or other practitioner, to:

Michigan Head•Pain & Neurological Institute
Attention: Medical Records Department
3120 Professional Drive
Ann Arbor, MI 48104-5131

INFORMATION TO BE DISCLOSED

☐ A letter containing case summary	
☐ Full medical record including mental health, substance abuse, or HIV/AIDS information	
☐ Behavioral Medicine notes from	to
☐ Billing information from	to
☐ Laboratory reports from	to
☐ Hospital discharge summary from	to
☐ Records from specific dates *(give dates)*	
☐ Other	

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

PURPOSE OF DISCLOSURE

- ☐ Patient's Own Use
  Reason:
- ☐ Employer Request
- ☐ Attorney Inquiry/Legal
- ☐ Social Security Disability Certification
- ☐ Continuation of Care/Consultation
- ☐ Workers' Compensation
- ☐ Insurance Claim/Application
- ☐ Transfer of Care
  Reason:
- ☐ Other *(specify)*

REVOCATION CLAUSE/SIGNATURE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Michigan Head•Pain and Neurological Institute (MHNI). I understand that the revocation will not apply to information that has already been released in response to this authorization.

SIGNATURE: _____ **DATE:** _____

Relationship: ☐ Patient ☐ Parent ☐ Legal Representative *(must include copy of guardianship papers of Power of Attorney)*

This authorization expires *(if left blank, expires 2 years from date above)*:

Please be certain to complete this form in its entirety
Allow 3 weeks for the processing of this request