FOREST VIEW MEDICATION MANAGMENT CLINIC
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____, DOB: ____,
Patient Name — Date of Birth

☐ authorize ☐ do **NOT** authorize

Forest View Medication Management Clinic (including all affiliated staff) to exchange information with:

____
NAME AND TITLE

____
ADDRESS

____
ADDRESS

____
CITY

____
PHONE NUMBER — FAX NUMBER

INFORMATION LIMITED TO:

☐ No Limitation (all records)
☐ Appointment Scheduling Information only
☐ Ongoing verbal exchange regarding my treatment
☐ Specific Dates of Treatment: ______________________________
☐ Other: ______________________________

FOR THE PURPOSE OF:

☐ Transfer of Care
☐ Coordination of Care
☐ Family Involvement in Treatment
☐ Personal Use
☐ Educational Services
☐ Legal
☐ Employment
☐ Disability
☐ Other: ______________________________

I understand such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time; if not revoked this consent will expire 12 months from the date signed below. I understand and consent for the medical record of the patient listed above to be copied and sent to the individual(s) as indicated. Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258 of 1974 as amended, Sections 748, 749, and 750). The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. This authorization is in compliance with Title 42 of the Code of Federal Regulations Part II, which also prohibits disclosure. **I have also had the opportunity to have this form explained to me and have my questions answered.**

______________________________ ______________________________
Patient Signature — Date — Witness Signature — Date

☐ Patient is a minor or dependant:

______________________________ ______________________________
Guardian/Parent Signature — Date — Relationship to Patient

Confidential Information: Any further release of this document without additional authorization by the patient will be a breach of confidentiality. Federal Regulation (2 CFP, Part 2) & State Laws (P.A. 258, Chapter 7, Section 748)

FOREST VIEW MEDICATION MANAGEMENT CLINIC
1055 Medical Park Drive, SE, Grand Rapids, MI 49546-3671
616.957.2235 or 800.949.8439 x235 Fax: 616.464.4234

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RELEASE OF INFORMATION CONSENT FOR OUTPATIENT RECORDS