Resilience
BEHAVIORAL HEALTH GROUP

8865 Professional Drive 3
Cadillac, MI 49601

Phone: (231) 285-0005
Fax: (231) 285-0004

resiliencebehavioralhealthgroup.com
info@resiliencebehavioralhealthgroup.com

Release of Information

Client Information

First Name _____ MI _____ Last Name _____

Address
_____

City _____ State _____ Zip Code _____

Date of Birth (DOB) _____ Phone Number _____

Email
_____

Release Information FROM

☐ Resilience Behavioral Health Group
8865 Professional Drive Suite 3
Cadillac, MI 49601
(231) 285-0005 (Phone)
(231) 285-0004 (Fax)
info@resiliencebehavioralhealthgroup.com

☐ Name
_____
Address
_____
City _____ State _____ Zip Code _____
Phone Number
_____
Fax Number
_____
Email
_____

Release Information TO

☐ Resilience Behavioral Health Group
8865 Professional Drive Suite 3
Cadillac, MI 49601
(231) 285-0005 (Phone)
(231) 285-0004 (Fax)
info@resiliencebehavioralhealthgroup.com

☐ Name

_____

Address

_____

City _____ State _____ Zip Code _____

Phone Number

_____

Fax Number

_____

Email

_____

This authorization will expire 1 year from the date of the signature unless another date is specified below. Expiration Date: _____

☐ **By checking this box,** I consent to the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box,** I also consent to the release of records for future visits after the date of my signature until this authorization expires or is revoked.

Purpose of Release

Please specify the intended purpose of releasing the information.

_____

Delivery of Information

Please specify the preferred method for delivering the information.

☐ Written and Verbal
☐ Written Only
☐ Verbal Only

Records to be Released

Timeframe or Date(s)

Please specify the timeframe in number of years or the date(s) of the information requested for release.

Timeframe: _____

Date(s): _____

Documents

Please specify the documents and/or type of information being requested for release. Select all that apply.

- ☐ Complete Health Record
- ☐ Assessment
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Psychological Testing Report
- ☐ Treatment Summary
- ☐ Service History
- ☐ Pertinent Information (Written and Verbal)
- ☐ Pertinent Information (Written Only)
- ☐ Pertinent Information (Verbal Only)

Note: Please be advised that the information to be released may include sensitive material related to mental health care.

Signed Authorization

- This authorization may be revoked at any time by providing a written notice of revocation to Resilience Behavioral Health Group.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer protected by the Federal Privacy Law (42 CFR Part 2) (HIPPA).
- I understand that Resilience Behavioral Health Group will not condition treatment on whether I sign this authorization.
- I may request a signed copy of this authorization from Resilience Behavioral Health Group.

- I may be charged for copies of this authorization by Resilience Behavioral Health Group in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed by Resilience Behavioral Health Group.
- I understand that Resilience Behavioral Health Group cannot ensure the privacy or security of the information disclosed once released.
- I agree that Resilience Behavioral Health Group is not responsible for what the recipient does with the information disclosed once released.

Note: A client 18 years of age or older must authorize the release of their own information unless the individual is incapacitated or deceased.
Note: If signing for minor client under 18 years of age, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require a minor client's authorization.
Note: Legal documentation of the right to access by the individual providing signed authorization if someone other than the client may be required.

Please provide information on the legal representative authorizing the *Release of Information* if someone other than the client. These fields must be completed by the legal representative of any client under 18 years of age or considered an incapacitated adult.

By signing this *Release of Information,* the client or the client's legal representative are acknowledging having read the document, understanding the content, and agreeing to the defined terms and conditions.

Client First Name* _____ Client Last Name* _____

Legal Representative First Name* _____ Legal Representative Last Name* _____

Description of Legal Representative's Authority* _____

Signature of the Client or Legal Representative* _____ Date* _____

Privileged & Confidential

This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged and confidential. If the reader of this message is not the intended recipient, please notify Resilience Behavioral Health Group immediately by telephone at (231) 285-0005. Copying or distributing such messages is strictly prohibited.