ANN ARBOR CONSULTATION SERVICES
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RELEASE OF INFORMATION/AUTHORIZATION FOR VERBAL OR WRITTEN COMMUNICATION OF PROTECTED HEALTH INFORMATION

All relevant sections must be completed in their entirety before any Protected Health Information will be released.

Client Name: ____________________ Client DOB: ____________

Parent/Guardian, Legal Representative Name (if applicable): ____________________

Relationship to Client (if applicable): ____________________

Street Address: ____________________

City: ____________ State: ______ Zip: ______ Phone #: ____________

Section I: Check this box if you are requesting that paper copies of your own records be sent to your own mailing address.

▢ I request AACS to release my protected health information to **myself** at the address listed above. (Please skip to Section V.)

Section II: Complete this section if you are requesting your own records be sent to or discussed with another individual/person or company/organization OR if you are the parent/guardian/legal representative requesting your dependent's records be sent to or discussed with another individual/person or company/organization.

▢ I am the client or legally authorized representative of the client listed above and request AACS to release my or my dependent's protected health information to:
▢ I am the client or legally authorized representative of the client listed above and request the person/organization listed below release my or my dependent's protected health information to AACS:

Individual/Person: ____________________ Company/Organization: ____________________

Street Address: ____________________ Phone #: ____________

City: ____________ State: ______ Zip: ______ Fax #: ____________

Section III: Please indicate the manner in which you are requesting Protected Health Information be released by selecting one of the three following options.

▢ Option #1: The information to be released is via *verbal communication only*. I am *not* requesting paper copies of records be sent to the individual/person or company/organization designated above in Section II.

▢ Option #2: I am requesting paper copies of records *and* AACS may also verbally discuss the content of the information released with the individual/person or company/organization designated above in Section II.

▢ Option #3: I am requesting *paper copies of records only*. AACS may *not* verbally discuss the content of the information released with the individual/person or company/organization designated above in Section II.

Section IV: Please complete this section only if you are authorizing verbal communication of protected health information (Options #1 or #2 above as outlined in Section III).

Specific information to be disclosed via verbal communication:
▢ Mental health diagnosis and treatment information
▢ Alcohol or other substance diagnosis and treatment information
▢ Attendance, billing, no-show or other information needed to process my insurance claim and/or manage my account
▢ HIV/AIDS status information
▢ Other (please specify): ____________________

 Client/Parent/Legal Representative Initials: ________

Section V: Please complete this section only if you are requesting paper copies of records (Options #2 or #3 above as outlined in Section III) and read and initial the statement regarding fees for medical records.

Specific information to be disclosed via paper records:
▢ Mental health diagnosis and treatment information
▢ Alcohol or other substance diagnosis and treatment information
▢ HIV/AIDS status information

Therapy Chart Forms:
▢ Demographic/Face Sheet
▢ Initial Therapy Assessment and Diagnostic Summary
▢ Treatment Plan(s)/Treatment Review(s)
▢ Progress Notes
▢ Discharge Summary
▢ Other (please specify): ___________________________
____

Psychiatric Chart Forms:
▢ Initial Psychiatric Assessment and Diagnostic Summary
▢ Session Progress Notes
▢ Medication Log
▢ Phone Call Notes/Refill Request Notes
▢ Discharge Summary
▢ Other (please specify): ___________________________________
____

I understand that there may be fees associated with record requests as outlined at the bottom of this document and that any fees will be due in advance of the records being sent. _______ (Initials)

Section VI: Please indicate the purpose for the authorized disclosure.

Purpose for Disclosure: ▢ Personal ▢ Coordination of care ▢ Change of Provider ▢ Social Security/Disability Certification ▢ Legal Matter ▢ Billing Department Coordination ▢ Other (please specify): ____

Section VII: Please read the paragraph below before signing the document.

I authorize AACS to release the information designated above (and ONLY the information designated above) that is protected under Code 42 of Federal Regulations, Part 2 including communications made by me to a social worker, professional counselor, psychologist, or psychiatric provider to the individual or organization listed above, for the purposes and conditions designated on this form. **I understand that this consent may be revoked at any time. AACS is not responsible for information released prior to revocation. I understand that in order to revoke this authorization, I may do so verbally (in person or over the phone) or in writing. I understand that this release expires 6 months after the above-listed client's discharge from AACS.**

____
Signature of Client, Parent. Legal Representative

____
Printed Name

____
Date

Relationship: ▢Self/Client ▢ Parent ▢ Legal Representative (must include copy of guardianship papers, power of attorney, or affidavit of heir at law)

Additional Information Regarding Your Request

Timeline for Processing Requests for Paper Records. All requests will be date stamped and logged. Records requests will take up to 30 days for charts on site at the Plymouth Road office and up to 60 days for charts at sites other than Plymouth Road (Stadium, Brighton) once any applicable fees have been collected.. Urgent requests will be processed sooner when possible.

Fees for Paper Records. Fees are authorized annually for the State of Michigan medical Records Access Act, P.A. 47 of 2004, MCL 333.26269. As such fees are as follows: (1) An initial fee of $23.71 per request for a copy of the record; (2) $1.19 per page for the first 20 pages; (3) $0.60 per page for pages 21 - 50; (4) $0.23 per page for pages 51 and up; and (5) any postage associated with sending the records. A patient shall not be charged the initial fee for the patient's own medical record. However, a patient can be charged the other permitted fees (e.g., the per page fees and the postage fees). See the complete Medical Records Access Act at: http://legislature.mi.gov/doc.aspx?mcl-Act-47-of-2004.