Community First Health Centers
Improving the quality of life for our community.

OFFICE USE ONLY
Date Received: _____ Provider's Initials: _____
Date Released: _____ Sender's Initials: _____

Authorization to Release Protected Health Information (Designated Record Set)

Please complete all parts of this form to enable us to fulfill your request for information.

1. Signing this authorization is voluntary. Community First Health Centers will not deny or change your treatment, payment, enrollment, or eligibility for benefits if you choose not to sign this form.

PATIENT FULL NAME	MAIDEN NAME OR AKA (ALSO KNOWN AS) NAME	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	EMAIL ADDRESS

RELEASE OF INFORMATION FROM COMMUNITY FIRST HEALTH CENTERS

2. Who should receive the information, and how should we send it?

☐ **MYSELF:** I request that Community First Health Centers release my protected health information to me.
Select the delivery method: ☐ Email ☐ Pick up in office ☐ U.S. Mail to address listed above ☐ Fax: _____

☐ **OTHER:** I am the patient or the patient's legally authorized representative. I request that Community First Health Centers release the protected health information of the patient listed above to the following person or organization:

INDIVIDUAL/PERSON	COMPANY OR ORGANIZATION

STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

Select the delivery method: ☐ Fax ☐ U.S. Mail ☐ Email

3. Purpose of release or disclosure of information:

☐ Continuation or transfer of care
☐ Legal/attorney
☐ Insurance company
☐ Workers' Compensation
☐ Patient request
☐ Other (please specify): _____

4. Records to be released by Community First Health Centers:

I authorize Community First Health Centers to release and/or receive the health information described below. This authorization applies to records related to my care and treatment, including medical records, x-rays, photographs, electronic and digital records, and any other health information, unless I specifically limit the information to be released. I understand that the records released under this authorization may include information related to the diagnosis, treatment, or referral for treatment of alcohol or substance abuse disorders that is protected by federal law (42 CFR Part 2); mental health, psychiatric, psychological, and social work services; and information regarding communicable diseases and infections as defined by Michigan law, including, but not limited to, tuberculosis, sexually transmitted diseases, and HIV/AIDS.

My health records may include information about:

This authorization does not permit the release of psychotherapy notes, which require a separate authorization.

Information to be released (please check all that apply):	**EXCLUDE the following information (check any information you do NOT want released):**
☐ Medical records* from these date(s) of service: _____	☐ Alcohol and substance abuse treatment records
☐ X-ray results (specify dates): _____	☐ Mental health records
☐ Lab results (specify dates): _____	☐ HIV/AIDS information
☐ Other records or information (please specify): _____	☐ Other (please specify): _____
☐ Entire medical record*	
☐ Minor-consented services, as allowed by Michigan law	

*The Designated Record Set

RELEASE OF INFORMATION TO COMMUNITY FIRST HEALTH CENTERS

5. Please send the requested records to the Community First Health Centers location selected below:

☐ Community First Algonac Health Center
ATTN: Medical Records
555 St. Clair River Drive
Algonac, MI 48001
FAX: (810) 794-7645

☐ Community First New Haven Health Center
ATTN: Medical Records
58144 Gratiot Avenue, PO Box 480430
New Haven, MI 48048
FAX: (586) 749-5560

☐ Community First Port Huron Health Center
ATTN: Medical Records
1011 Military Street
Port Huron, MI 48060
FAX: (810) 488-8005

☐ Community First Algonac Child and Adolescent Health Center
ATTN: Medical Records
5200 Taft Road
Algonac, MI 48001
FAX: (810) 777-9971

☐ Community First Port Huron Teen Health Center
ATTN: Medical Records
2215 Court Street
Port Huron, MI 48060
FAX: (810) 987-0651

Please send the Medical Records by:
☐ U.S. Mail ☐ Fax ☐ Email _____

I authorize release of health information to Community First Health Centers from:

NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

6. I understand that I may revoke this authorization at any time by submitting a written request to the attention of Medical Records at the Community First Health Centers location where I received services. I understand that revoking this authorization will not affect any information already released or actions taken before my revocation request is received.
   I understand that I may not be able to revoke this authorization if it was signed for the purpose of obtaining insurance coverage.
   I understand that I have the right to inspect or obtain a copy of the information to be used or disclosed, as permitted by 45 CFR § 164.524.
   I understand that this authorization will expire one (1) year from the date I sign it, unless I revoke it earlier. If I want this authorization to expire before one year, I have indicated the expiration date below:
   Expiration date: _____
7. I understand that, to help protect my health information, records sent by email will be encrypted and password protected unless I request otherwise. I understand that email communications sent over the Internet are not always secure and may be intercepted, accessed, or read by someone other than the intended recipient. By choosing to send or receive my health information by email, I acknowledge and accept these risks.

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE	PRINT NAME	DATE	TIME

IF THIS AUTHORIZATION INCLUDES RECORDS RELATED TO MINOR-CONSENTED SERVICES, THE MINOR PATIENT MUST SIGN THIS AUTHORIZATION WHEN REQUIRED BY APPLICABLE LAW.

			☐ TRANSLATION PROVIDED
WITNESS SIGNATURE	PRINT NAME	DATE	

The standards for Privacy of Personally Identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of this information. The federal confidentiality rules CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 1.

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