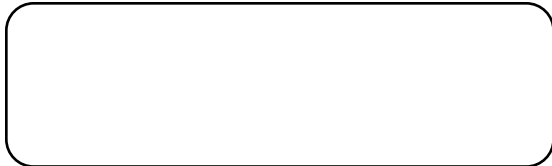




Palm Springs Treatment Center, LLC  
 DBA Michael's House  
 1910 S. Camino Real  
 Palm Springs, CA 92264



## Consent/Authorization to Use or Release Protected Health Information (PHI)

I authorize Palm Springs Treatment Center, LLC DBA Michael's House, 1910 S. Camino Real, Palm Springs, CA 92264 to use or to release the records checked below to:

Company Name/Contact \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Last 4 of SSN \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_

How may we release your information? (CHECK ALL THAT APPLY)  Phone/Verbal  Fax  Email  Mail

Specific dates of treatment to be released \_\_\_\_\_ OR All dates of treatment (check here)

### Information to be released (CHECK ALL THAT APPLY)

- |   |  |
|---|--|
| <input type="checkbox"/> Pre-Admission/Admission Documents                        | <input type="checkbox"/> Disability/FMLA Forms                               |
| <input type="checkbox"/> Insurance/Accounting/Billing Records                     | <input type="checkbox"/> Periodic Reports of Attendance/Participation        |
| <input type="checkbox"/> Clinical/Social History, Treatment Plans, Progress Notes | <input type="checkbox"/> Medical/Nursing History and Records                 |
| <input type="checkbox"/> Laboratory/Radiology Reports                             | <input type="checkbox"/> Discharge and Aftercare Documents                   |
| <input type="checkbox"/> Mental Health/Psychiatric History and Records            | <input type="checkbox"/> Administrative Documents (Consents, Releases, etc.) |
| <input type="checkbox"/> Other specific records (specify): _____                  |  |

### For the following purpose(s) (CHECK ALL THAT APPLY)

- |   |   |
|---|---|
| <input type="checkbox"/> Coordination of Care/Treatment Planning    | <input type="checkbox"/> School         |
| <input type="checkbox"/> Insurance Reimbursement/Appeals/Grievances | <input type="checkbox"/> Employment     |
| <input type="checkbox"/> Personal Use                               | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Other Purposes (please specify): _____     |   |

- Unless revoked, this authorization will remain in effect for 12 months from the date it is signed or until the date specified here: \_\_\_\_\_
- A photocopy or email copy shall be as valid as the original authorization.
- I understand that Substance Abuse records may include medical information relating to sensitive issues such as HIV/AIDS status and/or sexually transmitted diseases. With this authorization, I agree to allow such information to be released (if applicable) unless expressly prohibited by me here.
- \_\_\_\_\_ DO NOT release any HIV/AIDS or sexually transmitted disease information (**I realize this may result in some requested documentation not being released.**)
- I understand that I have the right to revoke this authorization both orally and in writing by providing a signed, written Notice of Revocation to Michael's House. However, the revocation will not be effective to the extent that Michael's House has used or disclosed information pursuant to this authorization before receipt of the revocation.
- Michael's House may not condition treatment based upon signature of this authorization.
- Federal Confidentiality Rules prohibit re-disclosure of information from drug and alcohol abuse records. However, HIPAA requires that Michael's House notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Authorized Representative's Signature  
 Authorized Representative's Relationship to Patient:

\_\_\_\_\_  
 Date