St. Clair County Community Mental Health

Authorization for Release of Information for Staff Testimony

IDENTIFYING INFORMATION

Individual:_____ CMH Case#:_____ DOB:_____ Gender:_____

Address:_____

Release effective date:_____

CMH AFFILIATE: St. Clair County Community Mental Health
3111 Electric Avenue, Port Huron MI 48060

Release Type:
☐ Release
☒ Exchange
☐ Request

Release to/Receive from:
☐ Family Member/Friend
☒ Organization
☐ Provide

I hereby authorize CMH to exchange information from my clinical record effective_____with:

Contact Name: St. Clair County Court System

Location Name: St. Clair County Courthouse

Address: 201 McMorran Blvd., Port Huron MI 48060

Phone: (810) 985-2031

Fax: (810) 985-2030

SPECIFIC INFORMATION TO BE REQUESTED

☒ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment
☒ Other: Verbal Testimony (see notes below)
☐ Check here if the specific information is related to alcohol, drugs – If abuse and/or other drugs, drug-testing results being shared between primary care physician and CMH

NOTES:_____

Authorization is given allowing verbal testimony regarding mental health treatment provided by subpoenaed CMH staff member, as well as preparations of the testimony with the attorney prior to the date of the testimony.

PURPOSE OR NEED FOR REQUEST/ DISCLOSURE

☐ Coordination of Benefits
☐ Coordination of Care
☐ Billing/Payment
☐ Coordination of Services
☐ Consumer Request
☒ Legal

EXPIRATION /REVOKE DATE/REASON

DATE:_____or Case Closure EVENT:_____ CONDITION: _____

- I understand that if the person(s) or organization(s) that receives the information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.
- I understand that I may inspect and/or obtain a copy of any information used/disclosed under this authorization.
- I understand this authorization will expire _____ (not to exceed 1 year), I further understand that I may revoke this authorization at any time by notifying Community Mental Health in writing but understand that previously disclosed information would not be subject to my evocation request.
- I understand that I may refuse to sign this authorization and that generally my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. When the exchange of PHI is specifically related to alcohol, drugs of abuse and/other drugs, or drug testing results, my treatment may be conditioned because my refusal to release the results could compromise my safety and the availability of medication appropriate for my treatment.
- I understand that these records may include information regarding mental health treatment, and/or alcohol or substance use, and/or information regarding HIV, AIDS, or the status of other communicable diseases.

SIGNATURES

Signature of Individual/Legal Guardian:_____ Date:_____

Witness Signature:_____ Printed Name:_____ Date:_____