BIOLOGICAL PSYCHIATRY CENTER, P.C.

25869 Kelly Road, Suite A
Roseville, MI 48066
(586) 773-6020

General Authorization Form

Patient Name: _____ **Birth Date**: _____ **SSN**: _____

Patient Address: _____
(No./Street/Apt.) (City/State/Zip)

I authorize Biological Psychiatry Center, P.C. to:

☐ **release** information to the party below **(and / or)** ☐ **request** information from the party below:

_____
(Contact Name)

_____
(No./Street address, Suite #/City/State/Zip)

_____ _____
(Office Phone Number) (Office Fax Number)

- I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A.258 of 1974 and 42 CFR Part 2).

Information to be released: ***(please clearly indicate requested information)***

☐ Initial Assessment	☐ History	☐ Subjective symptoms
☐ Medications/Prescriptions	☐ Laboratory/Blood work	☐ Immunizations
☐ Diagnosis/Prognosis	☐ X-rays/Radiology tests	☐ Complications
☐ Medical/Hospital Records	☐ Period of disability	☐ Communication

☐ Other: (***please specify items to be released)*** _____

Purpose of Release: _____

Please send: ☐ **All pertinent records** ☐ **Records from date range:** _____ **to** _____

This authorization expires on: _____ (specify expiration date or event)
(If left blank, this release will remain active for 90 days.)

- I understand that can revoke this authorization at any time by submitting a signed letter or countersigned release. Revocations will not apply to information that has already been released. The authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.
- I understand that, I as the client/parent/guardian who signed this form, can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, and any other applicable laws, rules and regulations.
- I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentially Laws (P.L. 104-191 (HIPPA), 45 CFR Parts 160 and 164).
- I am giving this consent voluntarily and have been informed of the specific information to be released.

Patient or Parent/Guardian Signature[1]: _____ **Date:** _____

BPC Person Executing Request: _____ **Date:** _____

~ Revocation of Release ~

Revoke: I confirm by my signature that I am revoking this authorization.

Patient or Parent/Guardian Signature: _____ Date: _____

[1] *Parent/guardian* indicates that patient is a minor or under care of legally recognized guardian.