HEALING MINDS OASIS

Healing Minds Oasis

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Tel: (248) 537-2646 Fax: (248) 301-0550
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RELEASE OF INFORMATION

Patient Name: _____Date of Birth_____

Home Address_____

I hereby authorize: Healing Minds Oasis, LLC

AND

Name_____

Address_____

Phone_____ Fax_____

Relationship to patient_____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER. Information contained in my patient records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a social worker, psychologist, counselor, physician assistant, nurse practitioner, physician; and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), only under the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED

☐ENTIRE RECORD	☐SCHOOL/WORK RECORDS	☐MEDICATION TREATMENT RECORD
☐COMMUNICATION EXCHANGE	☐DISABILITY PAPERWORK	☐ASSESSMENT/DIAGNOSIS
☐PSYCHOSOCIAL/COUNSELING	☐PROGRESS REPORTS	☐ADMISSION/DISCHARGE RECORDS
☐TREATMENT PLAN/CONTRACT	☐HOSPITAL RECORDS	☐OTHER_____
☐LAB RESULTS	☐DISCHARGE SUMMARY	_____

PURPOSE FOR DISCLOSURE

☐COORDINATION OF CARE	☐RETURN TO SCHOOL/WORK	☐_____
☐SCHOOL/WORK	☐OTHER_____	☐_____
☐REFERRAL FOLLOW UP	_____	☐_____
☐FAMILY NOTIFICATION	_____	

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Healing Minds Oasis, or their providers liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which the practice has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

_____	_____	_____	_____
Patient DOB	Patient/Legal Guardian name	Signature of Patient/Legal Guardian	Date

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

Date:_____ Event:_____ Condition:_____