Michigan THERAPY Institute

Quality, compassionate physical therapy for optimum results

Authorization to Release Information

Patient: _____ D.O.B. _____

Address: _____

By signing this form I authorize Michigan Therapy Institute, all locations, to release information in my medical record to the individual and/or organization listed below, and only under the conditions listed below.

1. **Name and address(es) of individual(s) or organization(s) to whom disclosure is to be made:**

_____

_____

_____

2. **The purpose or need for the information is for accurate diagnosis and/or treatment planning.**

3. **Specific information to be disclosed:**

❑ Individual Plan of Service ❑ Initial Evaluation ❑ Progress Notes ❑ Re-evaluations ❑ Discharge Report

❑ Other _____

In accordance with Title 42 of the Code of Federal Regulations (CFR) Part 11, ❑ I do authorize ❑ I do not authorize the release of records regarding drug/alcohol abuse.

In accordance with Act. No. 174, Section 5131, ❑ I do authorize ❑ I do not authorize the release of records regarding HIV infection, AIDS-Related complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), and/or other Communicable Diseases.

4. **<u>Duration of consent:</u> Without expressed revocation this consent expires <u>90 days</u> from the date of patient's signature.**

5. **<u>Revocation of consent:</u> This consent is subject to revocation at any time but not retroactive to the release of information made in good faith.**

_____ _____ _____ _____

Signature of Witness Date Patient Signature Date

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Relationship Date

This Authorization to Release Information form has been prepared in compliance with Title 42 of the Code of Federal Regulations, Part 11; in accordance with the authority specified in Public Act 56 of 1973; and in compliance with Section 748, Act 258, of the Michigan Mental Health Code.