CATHOLIC CHARITIES
WEST MICHIGAN

Authorization to Release Confidential Information

SECTION 1: Identifying information	
Client Name:	**Date of Birth:**

SECTION 2: Complete this section for the release of confidential information of minors
Minor Name(s) and Date(s) of Birth:

SECTION 3: With whom can we share information?

I hereby authorize Catholic Charities West Michigan (CCWM) to *

Request from ☐ **Request to** ☐ **Exchange with** ☐

the individual and/or organization listed below:

Name and/or Organization: *

Address: *

Phone: *

Fax:

E-mail:

SECTION 4: For what reason are records allowed to be shared with the above individual/organization? * SELECT ALL THAT APPLY

☐ Continuity of Care	☐ Legal	☐ Other (specify below):
☐ Care Coordination	☐ Benefits Claim	

SECTION 5: Which records can be shared? * SELECT ALL THAT APPLY

☐ Discharge Summary	☐ Progress Notes	☐ Other (specify below):
☐ Assessments, Evaluations	☐ Supervised Visitation Notes	
☐ Attendance, Dates of Service	☐ Treatment Plan, Service Plans, Reviews	

SECTION 6: How can the information be shared? * SELECT ALL THAT APPLY

☐ Mail	☐ E-mail	☐ In-Person
☐ Fax	☐ Phone	☐ Video, Audio Recording

SECTION 7: Other helpful information (optional)
CCWM Service:
Service Location:
Date(s) of Service:
Other Comments:

SECTION 8: Signature of individual or legal representative
I understand I am not required to complete this form. If I do not fill it out I can still receive treatment, health insurance, or benefits. However, without this form, CCWM may not have all the information needed for treatment.
I understand this authorization expires one year from the date signed below, unless I enter an earlier date or event (i.e. at the end of my treatment) here:
I understand my records may contain information related to drug and alcohol treatment and/or diagnosis, and/or treatment of HIV or other sexually transmitted diseases protected under CFR 42 Part 2, and other state and federal laws.
☐ **I authorize the release of information related to drug/alcohol treatment.**
☐ **I authorize the release of information related to treatment of HIV or other sexually transmitted diseases.**
Signature: * **Date: ***
Printed Name of Requestor: * **Legal Relationship to Client:**
Phone Number/E-mail (in case we need to reach you):

NOTICE TO RECIPIENT OF INFORMATION: If the disclosure involves mental health records, further release of information disclosed by the above authorization is prohibited by the Michigan Health Code, Section 748. The released information may not be copied, shared, or re-released except as consistent with the authorized purpose stated above. If the disclosure involves substance abuse treatment records, they are protected by Federal Confidentiality Rules, 42 CFR Part 2. Federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whose information is being disclosed or as otherwise permitted by 42 CFR. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

For Internal Use by Catholic Charities West Michigan Only
Internal Notes:
Revocation: I understand I may revoke this authorization at any time with written notice, however, previously authorized information released prior to the date of my signature below cannot be taken back.
☐ Revoke my authorization
Signature: Date:

How to Complete the Authorization to Release Confidential Information Form

Purpose: By law, Catholic Charities West Michigan (CCWM) is prohibited from releasing confidential information from a client record without the consent of the client (with a few exceptions). CCWM requires record requests be submitted in writing. The client (or legal representative) can request a copy of the record by using this form. CCWM will also accept forms from other entities that meet the criteria set forth by applicable state and federal laws.

Directions: FIELDS MARKED WITH A RED ASTERISK (*) ARE REQUIRED.

Section 1: Complete this form using the legal name and date of birth of the person for whom records are being requested.

Section 2: When requesting records pertaining to minors for which you are the legal representative, include minor name(s) and date(s) of birth.

Section 3: Identify if the records will be released, requested, or exchanged. Write the name of the individual and/or organization with whom you want this to occur. An address must be provided. Additional contact information is helpful if the records will be faxed or e-mailed to an individual/organization.

Section 4: Select the box(es) to indicate the purpose of sharing the records.

Section 5: Select the box(es) to specify each type of document that can be shared.

Section 6: Select the box(es) to specify how the records are to be shared (i.e. by mail, e-mail, fax, etc.).

Section 7: Please provide additional information such as service type, location, and dates of service to expedite the release of records.

Section 8: Read the authorization form. The authorization will EXPIRE one year after the date of the signature unless otherwise specified on the form. Print and sign your name. Date the release. Provide a phone number or e-mail address to reach you in case there are questions.

Fees: In accordance with the HIPAA Privacy Rule and the Medical Records Access Act, Public Act 47 of 2004, MCL section 333.26269, CCWM may require payment for the processing and release of records prior to releasing records to an individual or entity who is not the client. The table below outlines the CCWM Records Release Fee Schedule. Fees may be waived at the discretion of CCWM depending on the circumstances and nature of the release.

Requestor of Records	Type of Record	Fee
Client directed to self	Record delivered electronically or in paper format	No fee for the first set of records; $6.50 for each additional copy of requests more than 5 pages
Client directed to third party (i.e. doctor, attorney, etc.)	Record delivered electronically or in paper format	No fee for the first set of records; $6.50 for each additional copy of requests more than 5 pages
Third party request (i.e. insurance, attorney, DDS, etc.)	Record delivered electronically or in paper format	$6.50 flat fee for the first set of records and for each additional request, or the standard fee allowed by requesting entity, whichever is greater

Please submit the form using one of the following methods:

E-mail: compliance@ccwestmi.org
Mail: 40 Jefferson Ave SE, Grand Rapids, MI 49503
Fax: (616) 732-6391

Any questions regarding this form or the record release process may be directed to the Quality & Compliance Coordinator at (616) 551-5660. **Please allow up to 30 days to process the request.**