Palm Springs Treatment Center, LLC
DBA Michael's House
1910 S. Camino Real
Palm Springs, CA 92264

Consent/Authorization to Use or Release Protected Health Information (PHI)

I authorize Palm Springs Treatment Center, LLC DBA Michael's House, 1910 S. Camino Real, Palm Springs, CA 92264 to use or to release the records checked below to:

Company Name/Contact ______________________________

Address ______________________ City ______________ State _____ ZIP ________

Phone ______________ Fax ________________ Email ________________

Patient Name ______________________ DOB __________ Last 4 of SSN ________

Address ______________________ City ______________ State _____ ZIP ________

Phone ______________________________

How may we release your information? (CHECK ALL THAT APPLY) ☐ **Phone/Verbal** ☐ **Fax** ☐ **Email** ☐ **Mail**

Specific dates of treatment to be released ________________ **OR** All dates of treatment (check here) ☐

Information to be released (CHECK ALL THAT APPLY)

- ☐ Pre-Admission/Admission Documents
- ☐ Insurance/Accounting/Billing Records
- ☐ Clinical/Social History, Treatment Plans, Progress Notes
- ☐ Laboratory/Radiology Reports
- ☐ Mental Health/Psychiatric History and Records
- ☐ Other specific records (specify):______________________________
- ☐ Disability/FMLA Forms
- ☐ Periodic Reports of Attendance/Participation
- ☐ Medical/Nursing History and Records
- ☐ Discharge and Aftercare Documents
- ☐ Administrative Documents (Consents, Releases, etc.)

For the following purpose(s) (CHECK ALL THAT APPLY)

- ☐ Coordination of Care/Treatment Planning
- ☐ Insurance Reimbursement/Appeals/Grievances
- ☐ Personal Use
- ☐ Other Purposes (please specify): ______________________________
- ☐ School
- ☐ Employment
- ☐ Legal Purposes

- Unless revoked, this authorization will remain in effect for 12 months from the date it is signed or until the date specified here: ______
- A photocopy or email copy shall be as valid as the original authorization.
- I understand that Substance Abuse records may include medical information relating to sensitive issues such as HIV/AIDS status and/or sexually transmitted diseases. With this authorization, I agree to allow such information to be released (if applicable) unless expressly prohibited by me here.
- ____ DO NOT release any HIV/AIDS or sexually transmitted disease information **(I realize this may result in some requested documentation not being released.)**
- I understand that I have the right to revoke this authorization both orally and in writing by providing a signed, written Notice of Revocation to Michael's House. However, the revocation will not be effective to the extent that Michael's House has used or disclosed information pursuant to this authorization before receipt of the revocation.
- Michael's House may not condition treatment based upon signature of this authorization.
- Federal Confidentiality Rules prohibit re-disclosure of information from drug and alcohol abuse records. However, HIPAA requires that Michael's House notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules.

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Authorized Representative's Signature Date
Authorized Representative's Relationship to Patient: ______________________________

REVISION DATE: 6.28.2018