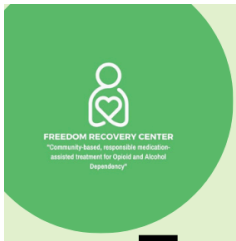

Freedom Recovery Center

Phone: 517-881-6199 or 517-599-4894 Fax: 989-340-1512
Website: Freedomrecoverycenter.net

Freedom Recovery Center Authorization to Obtain/Disclose Health Information:

Patient Name: _____ _____ _____
Previous Name(s): _____DOB: _____
Complete Address:
_____
_____
City: _____ State: _____ Zip Code: _____
Phone: _____ Email:_____
I hereby authorize Freedom Recovery Center:
To disclose information from my medical record to and/or obtain information from:
Requester's Legal Business Name:
_____
_____
Requester's Complete Address:
_____
_____
City: _____ State:_____ Zip Code:_____
Phone: _____
Email:_____

By signing this authorization form, I understand that:

- The authorization is voluntary and that my records may include protected information relating to AIDS, HIV testing and results, behavioral health treatment, treatment for alcohol, drug and/or substance abuse.
- Requests for copies of medical records are subject to fees allowed by Law. Freedom Recovery Center's policy does not allow for fees to exceed $25 in total.
- In the case that Freedom Recovery Center is requested by a third party to create health information solely for sharing that information with the party that requested it, I understand that I must sign this authorization.

- I may change my mind and cancel (revoke) this authorization. I have the right to revoke this authorization at any time. This authorization may be revoked in writing to the Program Director of Freedom Recovery Center. Revocations will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization is expected to expire: _____. If I fail to specify an expiration date/event/condition, this authorization will expire a year after signing.
- I understand that the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that I may inspect or copy the information to be used or disclosed and I may receive a copy of this signed authorization.

If this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following will apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) prohibit you from making any further disclosure of it without written consent of the person to whom it pertains, and/or otherwise permitted by such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

Return completed authorization to the address listed below:

Freedom Recovery Center
Attn: Medical Records Department
165 N. State Ave.
Alpena, MI 49707
ROI fax number: (989)340-1512
Signature of Patient or authorized Representative:
_____
Date:
_____
Relationship to Patient: _____
*a copy of the authorized representative's legal authority to act on behalf of the patient must be attached.
Questions? Please call Freedom Recovery Center directly at (517)881-6199