Information Release Authorization

Neurobehavioral Medicine Group
Richard Jackson, M.D.
W-4111 Andover Road, Suite 100
Bloomfield Hills, MI 48302
Tel: 248-290-5400 Fax: 248-290-5401

I _____, _____
(Patient) (Date of Birth)

_____, _____
(Parent or Guardian if a minor) Date of this request

hereby authorize the release of Protected Healthcare Information specified below between Dr. Richard Jackson and/or Neurobehavioral Medicine Group and:

Name:_____ Phone: _____

Address: _____ City/Zip: _____

This release allows Dr. Richard Jackson, Neurobehavioral Medicine Group &/or its designee and the above named entity &/or its designee to release information contained in my records, including mental health records protected by Michigan Public Act 290 of 1996 (The Mental Health Code), if any, and alcohol and drug abuse records protected by Code 42 of Federal Regulations, Part 2 and protected health information protected by the Health Insurance Portability and Accountability Act of 1996. This includes medical services records, psychological/mental health services records, communications made to me by my psychiatrist, psychologist, social worker or other health care provider, and information regarding communicable diseases and infections which, as defined by Michigan Department of Community Health Rules, include venereal disease, tuberculosis, hepatitis B, Human immunodeficiency virus, and acquire immunodeficiency syndrome.

1. Specific type of information to be disclosed: _____All pertinent information_____

_____

2. The purpose and need for such disclosure: _____Continuity of care_____

_____

3. This authorization shall be in effect until _____ at which time this authorization to disclose protected health information expires.

* I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer c/o Dr. Richard Jackson and/or Neurobehavioral Medicine Group.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
* I understand that the practice will not condition my treatment on whether I provide authorization for the requested use or disclosure.
* I understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under federal law.

_____/_____ _____/ _____
Signature of Patient or Guardian Date Witness to Signature Date