GREAT MINDS

…fostering success in development, learning and living

GREAT MINDS OF MICHIGAN PLLC
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize and request Great Minds of Michigan, PLLC ("GREAT MINDS") to disclose my confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above from _____ to:

Name: _____

Organization: _____

Address: _____

City:_____ State: _____ Zip: _____

Telephone: _____ Fax:_____

Name: _____

Organization: _____

Address: _____

City:_____ State: _____ Zip: _____

Telephone: _____ Fax:_____

I specifically authorize any current employee or owner of GREAT MINDS or GREAT MINDS related entities, or any other individual listed below, to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Purpose(s) of the information

_____

_____

_____

Description of the information to be used or disclosed

- ❑ Psychological or neuropsychological evaluation reports
- ❑ Summary of treatment progress
- ❑ Other:_____

This authorization is for GREAT MINDS's own use, and GREAT MINDS will not condition treatment or payment on this authorization, except (1) if treatment is related to research, or (2) health care services are provided solely for the purpose of creating protected health information for disclosure to a third party. The patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that GREAT MINDS has acted in reliance on this authorization. In order for the revocation of this authorization to be effective, GREAT MINDS must receive a **written** notification stating the patient's desire to revoke the authorization. GREAT MINDS will accept written revocations of this authorization via certified U.S. Mail. All revocations must be sent to GREAT MINDS, to 23210 Greater Mack Ave., #216, Saint Clair Shores, MI 48080. Revocations are not effective until received by Dr. Reed.

Expiration

This authorization shall remain valid until: _____

After this date/event, GREAT MINDS can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient or Parent's signature: _____

Date: _____
cc: Patient