Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person, provider, or agency to access or exchange your medical information. (This includes health information, which is any information that relates to your past, present, or future physical or mental health or medical condition.) I authorize the disclosure of my personal health information as described below. I understand that this authorization is voluntary.

I hereby give permission to M&M Behavioral Health Solutions, LLC to release information to and/or obtain information from the following:

Name: _____

Address: _____

Telephone/Fax:_____

Personal Health Information to be disclosed: Verbal and written communication of ALL records/pertinent information needed for the purpose of rehabilitation, treatment, services and the complete continuation of care for the consumer.

Right to revoke: I may revoke this authorization at any time except to the extent that action has been taken. If I do not revoke it, this authorization will expire upon my discharge from the agency. To revoke this authorization, I will contact the Program Director/Coordinator and make a written request to cancel consent.

I, _____ , DOB:_____ SS# _____ have had full opportunity to read the contents of this authorization and I confirm that the contents are consistent with my direction to the person named above. I understand that by signing this form, I am confirming my authorization that the above named person(s) or organization may use and/or disclose nonpublic personal health information described in this form.

Signature of Client:_____

Witness/Staff Signature:_____

**If a personal representative, on the behalf of this individual signs this authorization, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____