M & M Behavioral Health Solutions, LLC

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Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person and/or provider to access and/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 describe 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:

Information is released to: ____

Address: ____

Telephone/Fax: ____

Personal Health Information to be disclosed: Verbal, written and electronic 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 with expire one year after the date on which signed. 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 Consumer: ____ Date: __________________________

Witness: ____ Date: __________________________

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

Personal representative's Name: ____

Relationship to Individual: ____