



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization allows AICM - Michigan to obtain and share protected medical and health information when needed to coordinate case management services and communicate with the treatment team.

1. CLIENT INFORMATION

Full Name Date of Birth
Address Phone
City State ZIP Email

2. AUTHORIZATION

I authorize AICM - Michigan to obtain, use, disclose, and exchange my protected health information (PHI) with the persons and organizations identified below for purposes related to case management, care coordination, treatment planning, and communication with my treatment team.

3. INFORMATION AUTHORIZED FOR RELEASE / EXCHANGE

- | | |
|---|--|
| ☐ Medical records and history | ☐ Medication information |
| ☐ Treatment plans and progress notes | ☐ Billing / insurance information |
| ☐ Discharge summaries | ☐ Physician and provider reports |
| ☐ Diagnostic testing and imaging | ☐ Hospital / facility records |
| ☐ Therapy and rehabilitation records | ☐ Case management records |

Other:

4. PERSONS / ORGANIZATIONS WITH WHOM INFORMATION MAY BE SHARED

- | | |
|---|---|
| ☐ Treating physicians and healthcare providers | ☐ Pharmacies and equipment providers |
| ☐ Therapists and rehabilitation providers | ☐ Other members of my treatment team |
| ☐ Hospitals and medical facilities | ☐ Insurance carriers, as applicable |

Other:

5. PURPOSE OF DISCLOSURE

- | | |
|--|---|
| ☐ Case management and care coordination | ☐ Monitoring progress and outcomes |
| ☐ Treatment planning and provider communication | ☐ Medical necessity / insurance coordination |

Other:



AUTHORIZATION TO RELEASE MEDICAL INFORMATION - CONTINUED

6. EXPIRATION AND REVOCATION

Unless I specify an earlier date or event below, this authorization will expire one (1) year from the date signed. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

Earlier expiration date or event:

7. CLIENT ACKNOWLEDGMENT

I understand that signing this authorization is voluntary. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I authorize AICM - Michigan to rely on this authorization for the purposes stated above.

8. SIGNATURE

Client / Authorized Representative Signature

Date

Printed Name

Relationship / Authority

9. OPTIONAL CONTACT / DELIVERY INSTRUCTIONS

Specific provider / organization (if applicable)

Address / Fax / Email for records (if known)