



Section A: Authorization

I authorize the use and disclosure of my psychotherapy notes, as described in Sections B and C below. I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this authorization.

NAME		DAYTIME PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	CONTRACT NUMBER		

Section B: Information for Use and Disclosure

Describe in detail the information to be used and disclosed (providers, dates of treatment, type of service, etc.):

Section C: Authorized Use and Disclosure

NOTE: Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by privacy laws.

- I authorize BCN Family Health Center to disclose my psychotherapy notes, described in Section B, to the following person(s) and entities:

The purpose for the disclosure is _____

- I authorize the following person(s) and entities to disclose my psychotherapy notes, described in Section B, to the BCN Family Health Center:

I authorize the Family Health Center to use my psychotherapy notes, described in Section B, for the following purposes:

Section D: Expiration and Revocation

This authorization will expire: On _____; OR when the following occurs: _____

I can revoke this authorization at any time by sending a written request on a standard form, available from the Family Health Center where I receive care. I understand that revocation will not affect actions taken before BCN receives my request.

Section E: Signature

Signature: _____ Date: _____

If you are not the patient, please sign and write today's date below, then check the box that describes your relationship to the patient. If you are not the parent of the patient, please attach proof of your relationship to the patient. NOTE: An authorization is required if you are not the personal representative.

Print Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

- Parent Legal Guardian Power of Attorney Executor Other _____

WE WILL MAIL YOU A COPY OF THIS COMPLETED AND SIGNED AUTHORIZATION

Please return this form to the Family Health Center where you receive your care:

Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917	Family Health Center – Lake Lansing 1525 W. Lake Lansing Road East Lansing, MI 48823	Former patients of Fashion Square, Essexville, and Midland Family Health Centers return forms to: Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
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INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF
PSYCHOTHERAPY NOTES

The Authorization is not valid unless it is filled out completely.

Section A: Authorization

- 1) Patient's first and last name
- 2) Patient's full street address, including city, state and ZIP code
- 3) Patient's date of birth
- 4) Patient's telephone number, including area code

Section B: Information for Use and Disclosure

- 1) List in detail the information to be used or disclosed (for example detail providers name, dates of treatment, type of service, etc.)

Section C: Authorized Use and Disclosure

- 1) List all persons and entities that patient authorizes to disclose (release) the psychotherapy notes described in section B to the Family Health Center. If at your request, simply state "at my request."
- 2) Detail the purposes for which the patient authorizes the Family Health Center to use the psychotherapy notes described in section B. If at your request, simply state "at my request."

Section D: Expiration and Revocation

- 1) Fill in the date for when the patient would like the authorization to expire (day, month and year) or if applicable, the event or activity that will trigger the expiration of the authorization.
- 2) If the patient would like to revoke the authorization, he or she may do so at any time. The request must be submitted in writing using the standard FHC revocation form. The patient may obtain a standard form by calling the health center where they receive their care.

Section E: Signature

The patient must sign and date the authorization.

- 1) If a personal representative is signing the authorization form on behalf of a patient, the representative must sign his or her name in the space below the signature line and specify his or her relationship to the patient by checking the appropriate box below the signature.
- 2) If the personal representative is someone other than the parent of a minor child named as the patient, he or she must attach proof of signature authority.

The signer will receive a copy of the completed authorization form via return mail. The operating unit that processes the authorization will retain the original.