CHILD AND ADOLESCENT HEALTH CENTER PROGRAM

Release of Information Request

I, _____

Printed Name **Date of Birth**

_____

Present address

Authorize **Bluejay Wellness Center** to obtain or release the following information:

☐ Receive information from: OR ☐ Release the above information to:

Doctors' office: _____

Telephone Number

_____

Address **City, State** **Zip Code**

The purpose of the request is at the request of myself or at the request of_____

_____.

This authorization expires one year from the date of my signature, or on _____.

- I understand that I may revoke this authorization in writing to:
  Bluejay Wellness Center, Address: 238 S. Chippewa, Shepherd MI 48883
- I understand that information used or disclosed to the recipient of the information I have requested above may be subject to redisclosure by the recipient and no longer is protected by the HIPAA Privacy rule.
- I understand that the Child and Adolescent Health Center Program will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- Under Michigan Law, I understand that minors may, without parental consent, receive advice, testing and/or treatment for substance abuse, sexually transmitted diseases, HIV, and mental health services, which, are defined as Confidential Services, and I must consent to the release of my personal health information to any individual, parent, or guardian.

_____ AND/OR _____

Client Signature Date Parent/Guardian Date

_____

Witness

Original to requested person/agency **Copy to CAHC** **Copy to Client**

The Child and Adolescent Health Center Program is operated by the CMDHD, with major funding from the Michigan Departments of Community Health and Education.