

**MICHIGAN HEAD•PAIN & NEUROLOGICAL INSTITUTE**

3120 Professional Drive • Ann Arbor, MI 48104-5131

(734) 677-6000 • FAX (734) 677-2422

**AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION  
FROM OR TO MICHIGAN HEAD•PAIN & NEUROLOGICAL INSTITUTE (MHNI)**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Street Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

**RELEASE OF MHNI INFORMATION**

I authorize Michigan Head•Pain & Neurological Institute (MHNI) to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, behavioral medicine services records, including communications made by me to a psychologist or other practitioner, to the individuals or organizations listed below, only under the conditions listed below. I understand that MHNI may charge me for this service as outlined in the attached letter.

\_\_\_\_\_  
Name(s) of person or organization to whom disclosure is to be made

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number, FAX Number

**IF REQUESTING MHNI INFORMATION,  
RETURN THIS FORM TO:**  
Michigan Head•Pain & Neurological Institute  
Medical Records Department  
3120 Professional Drive  
Ann Arbor, MI 48104-5131

**TO HAVE INFORMATION SENT TO MHNI**

I authorize

\_\_\_\_\_  
Name(s) of person or organization whom will make disclosure

to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, behavioral medicine services records, including communications made by me to a social worker, psychologist or other practitioner, to:

**Michigan Head•Pain & Neurological Institute  
Attention: Medical Records Department  
3120 Professional Drive  
Ann Arbor, MI 48104-5131**

**INFORMATION TO BE DISCLOSED**

- A letter containing case summary
- Full medical record including mental health, substance abuse, or HIV/AIDS information
- Behavioral Medicine notes from \_\_\_\_\_ to \_\_\_\_\_
- Billing information from \_\_\_\_\_ to \_\_\_\_\_
- Laboratory reports from \_\_\_\_\_ to \_\_\_\_\_
- Hospital discharge summary from \_\_\_\_\_ to \_\_\_\_\_
- Records from specific dates (*give dates*)
- Other \_\_\_\_\_

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

**PURPOSE OF DISCLOSURE**

- Patient's Own Use  
Reason: \_\_\_\_\_
- Employer Request  
Reason: \_\_\_\_\_
- Attorney Inquiry/Legal  
Reason: \_\_\_\_\_
- Social Security Disability Certification
- Continuation of Care/Consultation
- Workers' Compensation
- Insurance Claim/Application
- Transfer of Care  
Reason: \_\_\_\_\_
- Other (*specify*) \_\_\_\_\_

**REVOCACTION CLAUSE/SIGNATURE**

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Michigan Head•Pain and Neurological Institute (MHNI). I understand that the revocation will not apply to information that has already been released in response to this authorization.

**SIGNATURE:**

**DATE:**

Relationship:  Patient  Parent  Legal Representative (*must include copy of guardianship papers of Power of Attorney*)

This authorization expires (*if left blank, expires 2 years from date above*): \_\_\_\_\_

**Please be certain to complete this form in its entirety  
Allow 3 weeks for the processing of this request**