5130 Rose Hill Blvd.
Holly, MI 48442-9507
Phone: 248.531.2405
Fax: 248.634.7754
rosehillcenter.org

AUTHORIZATION TO RELEASE INFORMATION

Patient Name ________________________________

SSN ________________________________ DOB ______________________

I authorize ____

to release information specified below to

Admissions Department
Rose Hill Center
5130 Rose Hill Blvd.
Holly, MI 48442

This release of information is (✓) is not (   ) a reciprocal release of information.

Information to be released may include psychiatric/psychological, substance use disorder treatment records and AIDS, HIV + information, if applicable.

Information requested includes **All psychiatric records**

The purpose and need for such disclosure **Admission**

The patient may revoke this authorization at any time. If not previously revoked, **this consent will expire one year from date of signature or upon discharge from Rose Hill Center,** whichever occurs first. This authorization is valid only for the information, agencies and person cited above.

Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Rose Hill Center. Any further disclosure of this information is not permitted without specific authorization to do so.

I may refuse to sign this authorization. My care or treatment will not be conditioned on signing this authorization.

Patient signature ________________________________ Date

Guardian signature (if applicable) ________________________________ Date

Witness signature ________________________________ Date

This information release authorization form has been prepared in compliance with Title 42 of the Code of Federal Regulations. Part II; in accordance with the authority specified in Public Act 56 of 1973; and in compliance with Section 748, Act 258, 1974, “Michigan Mental Health Code.”

☐ Release Rescinded

Signature of Resident ________________________________ Date

Signature of Witness ________________________________ Date