Ashwini Gulwadi, PLLC
101 W. Liberty, Suite 360, Ann Arbor, MI 48104
Ph: 734-984-2228 Fax: 734-984-2008

AUTHORIZATION TO DISCLOSE AND/OR RECEIVE HEALTH INFORMATION

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Patient's Name			**Patient's ID** (driver's license number)
Street Address			**Patient's Date of Birth** / /
City	**State**	**ZIP**	**Phone** ( ) _

A. INFORMATION TO BE DISCLOSED AND/OR RECEIVED: In order to disclose protected health information for any reason other than for treatment, payment, health care operations, performing certain insurance functions, or as otherwise required or permitted by law, Medical Practice and its health professional(s) and staff (collectively, the "Practice") must obtain your signed authorization. Complete the following to indicate those items you authorize the Practice to disclose. To authorize the disclosure of all health information which the Practice creates, receives or maintains, check the first box.

I authorize the Practice to disclose and receive(exchange) the health information checked below concerning the above-named patient. I understand that this information may include, when applicable, information relating to Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), behavioral or mental health services (excluding psychotherapy notes), and/or information that might identify the above-named patient (directly or indirectly) as having or having had a substance use disorder (as permitted by MCL §330.1748, MCL §330.1262, and/or 42 CFR Part 2).

- □ **All Health Information including medical and psychiatric information and psychiatric progress notes**
- □ **lab reports and reports of testing done by other psychiatrists or therapists or other facilities**
- □ **Substance use history**
- □ **specify information**_____

_____ **Limited Dates of Service.** If initialed here, I authorize the Practice to disclose the above health information only for the following Dates of Service *(e.g., health information for the past two years. If authorizing disclosure of all Dates of Service, skip.)*:
_____

_____ **Exclusions**. If initialed here, I DO NOT authorize the Practice to disclose the following health information concerning the above-named patient: _____

B. WHO CAN RECEIVE AND/OR DISCLOSE AND THUS USE THE HEALTH INFORMATION:

The following person or facility is authorized to both disclose and receive / exchange my protected health information including all psychiatric health information:
Ashwini Gulwadi, M.D., Ashwini Gulwadi, PLLC, 2100 S. Main St., Suite A, Unit 4, Ann Arbor, MI 48103. Ph: 734-984-2228 Fax: 734-984-2008

The following person or facility is authorized to both disclose and receive / exchange my protected health information including all psychiatric health information:

_____ _____
(Authorized Person/Individual's Name) **(Authorized Organization Name)**

_____
Street Address

_____
City, State, ZIP

_____
Phone Number (Include Area Code) Fax Number (Include Area Code)

C. REASON FOR DISCLOSURE: This disclosure and use is initiated at the request of the individual. (Note: You may state a specific purpose below; however, you are not required to do so:

- □ **Assisting with evaluation and diagnosis/es clarification**
- □ **Coordination of care/ coordination of services**
- □ **both assisting with diagnoses clarification and coordination of services**
- □ **other: _____**

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D. **EFFECTIVE TIME PERIOD:** Unless permission is revoked, this Authorization is valid for the entirety of the time that I am an active patient at Ashwini Gulwadi PLLC, and Ashwini Gulwadi, M.D. When the treatment relationship with Dr. Gulwadi is terminated, this form is no longer effective. I understand that I will need to contact Dr. Gulwadi when I want to revoke the permission at any point of time.

E. **RIGHT TO REVOKE AUTHORIZATION:** I understand that I have the right to change my mind and to **revoke my permission at any time**. I understand that this must be done by giving written notice stating my intent to revoke this Authorization to the Practice. I understand that any uses or disclosures already made with this Authorization cannot be revoked.

If this Authorization is needed as a condition to obtain health care coverage and I revoke it, I understand that the person/organization named under "Who Can Receive and Use the Health Information" who would have received the information may have the right to contest health care coverage claims.

F. **SIGNATURE AUTHORIZATION:** I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this Authorization, I understand that except as otherwise provided in this Authorization, any disclosure of information carries with it the potential for a re-disclosure by the recipient without my authorization and that the information may not be protected by federal or state privacy laws and rules. I understand I may request a copy of this signed Authorization. I acknowledge that a paper or electronic copy of this Authorization may be relied upon the same as the original document with my wet-ink signature.

Legal Representative's Name (If applicable)	**Legal Representative's Relationship to Patient** (A letter of authority may be requested.)
Signature of Patient or Legal Representative	**Date** / /
Signature of Witness	**Date** / /

FOR DISCLOSURES OF SUBSTANCE USE DISORDER PATIENT RECORDS ONLY, IF SUBJECT TO 42 CFR Part 2

TO THE AUTHORIZED PERSON/ORGANIZATION IDENTIFIED IN §B: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.