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
P: 248-531-2405
F: 248-634-7754

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.

ANY FURTHER DISCLOSURE OF THIS INFORMATION IS NOT PERMITTED WITHOUT SPECIFIC AUTHORIZATION TO DO SO.

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☑ Release Rescinded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