MICHIGAN DEPARTMENT OF CORRECTIONS – Bureau of Health Care Services

CHJ-718
3/2024

PATIENT'S AUTHORIZATION FOR VERBAL DISCLOSURE OF HEALTH INFORMATION

Name:	**Number:**	**D.O.B.**

(PRINT OR TYPE FULL NAME OF PATIENT)

Information to be released to:		
	Contact Number	**Relationship**

SPECIFIC INFORMATION: ☐ Medical ☐ Dental ☐ Mental Health ☐ Complete Health Record

Other – Specify: ______________________________

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I authorize the person listed above to be involved in verbal discussions regarding my healthcare. This individual may receive any verbal information necessary to participate in my care or assist me in making informed decisions.

By signing this form, I permit staff within the Michigan Department of Correction to discuss my medical information with the authorized person listed above.

I understand that listing an individual on this form does not grant them the right to receive copies of my medical records. Requests for copies of medical records must be submitted using the Patients Authorization for Written Disclosure of Health Information form (CHJ-121). This authorization also does not empower them to consent to healthcare services on my behalf.

Unless otherwise revoked, this authorization will expire on the specified date or event selected below. If I fail to specify an expiration date or event, this authorization will expire one year from the signature date, or upon release, whichever comes first.

☐ Upon Release ☐ Other Event____________ ☐ 1 Year from Signature ☐ Specified Date____________

I understand that I may revoke this authorization in writing at any time. Unless revoked, this release will expire as outlined above.

I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I hereby consent to the disclosure of the above-described information contained in the health record identified on this form.

Date:	**PATIENT / MINOR'S PARENT / GUARDIAN / MEDICAL POWER OF ATTORNEY SIGNATURE**
Date:	**WITNESS SIGNATURE**

1 Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose (21 USC 1175; 42 USC 4582).

2 Michigan Public Health Code (MCL 333.1101 et seq.); Medical Records Access Act (MCL 333.26261 et seq.). 2014-2015 Appropriation Bill.

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