Michigan Youth ChalleNGe Academy
5500 Armstrong Rd., BLDG 13
Battle Creek, Michigan 49037

AUTHORIZATION TO DISCLOSE INFORMATION

Applicant's Name _____ Date of Birth _____

I, _____ (Parent/Guardian) hereby authorize _____ (Name of Mental Health Provider/Organization)

_____ (Address) to exchange/release the following information with Michigan Youth ChalleNGe Academy (Name of Person /Organization)

5500 Armstrong Rd., BLDG 13, Battle Creek, MI 49037
(Address) (State and Zip Code)

X Verbal Exchange of Information X Send Information to X Obtain Information From

SPECIFIC INFORMATION TO BE DISCLOSED:

Time frame of records needed: **2021 - CURRENT**

☐ School Record ☐ Mental Health Background ☐ Physician / Health Care Provider
☐ Progress Notes/ Discharge Summary ☐ Medications ☐ Case Management Services
☐ Hospital Records/ Lab Results ☐ Mental Health Therapist/Provider ☐ Legal

X Michigan Youth ChalleNGe Academy Mental Health Summary (attached)

Any Information not to be released: _____

Reason for Disclosure: POSSIBLE ADMITTANCE TO MICHIGAN YOUTH CHALLENGE ACADEMY

This Authorization will expire one year from date of client signature unless specified: _____. I understand that my records are protected by State and Federal Confidentiality Rules and cannot be disclosed without my written authorization unless release is required by other regulations. I also understand that I may revoke this authorization at any time in writing except to the extent that action has already been taken. I understand that medical information may include records, if any, on psychology, social work, and information about alcohol, drug abuse, HIV, AIDS, and ARC may be released as permitted by law. I understand that treatment, enrollment or eligibility for services will not be conditioned on signing this authorization. I understand there is a possibility the protected health information may be re-disclosed by the recipient of the information and no longer protected by Privacy Rules.

_____ _____
Applicant's Signature Date of Signature

_____ _____
Signature of Parent/Guardian/Legal Representative Date of Signature

NOTE TO RECEIVING AGENCY: This information has been disclosed to you from records protected by law. An individual receiving information made confidential shall disclose the information to others only to the extent consistent with the authorized purpose for which it was obtained. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

To be completed by parent/guardian and applicant.