Community Care Services

Providing Hope Building Recovery

Administrative Offices – 26184 West Outer Drive, Lincoln Park, MI 48146 – (313) 389-7500

Susan Kozak L. M.S.W
Executive Director

OUTPATIENT PROGRAMS

26184 W. Outer Drive
Lincoln Park, MI 48146
(313) 389-7500
Fax (13) 389-7510

26650 Eureka Rd. Ste A
Taylor, MI 48180
(734) 955-3550
Fax (734) 955-3562

ASSERTIVE COMMUNITY TREATMENT PROGRAMS

DUAL DIAGNOSIS/ACT
26180 W. Outer Drive
Lincoln Park, MI 48146
(313) 294-8821
FAX: (313) 294-8824

HOMELESS RESOURCE TEAM
26180 W. Outer Drive
Lincoln Park, MI 48146
(313) 294-8821
FAX: (313) 294-8824

HORIZONS
26180 W. Outer Drive
Lincoln Park, MI 48146
(313) 294-8821
FAX: (313) 294-8824

MCOIT
26180 W. Outer Drive
Lincoln Park, MI 48146
(313) 389-2209
FAX: (313) 383-7293

TURNING POINT
1605 Fort Street
Lincoln Park, MI 48146
(313) 382-7861
FAX: (313) 382-7906

ACCREDITED BY:
THE JOINT COMMISSION

Authorization to Release Information

Client Name: _____ Date of Birth: _____ SS#: _____

Address: _____

I, _____, authorize Community Care Services to disclose the following protected health information in my personal record:

- ☒ Discharge Summary
- ☒ Diagnostic Test Results and Medication
- ☒ Mental Health Treatment Services
- ☒ Psychosocial Assessments
- ☒ Treatment Plan/ Record
- ☒ Progress Notes
- ☒ Social Assessment
- ☒ Diagnosis/Prognosis
- ☒ Academic, Vocational and/or Special Education Information
- ☒ Information about HIV/AIDS or other communicable diseases as defined by Public Act 1989
- ☒ Information regarding Substance Abuse Treatment
- ☒ Other medical information (medical history, lab results, medication conditions)
- ☐ Other:

The specific need and disclosure for this information is :

- ☐ Provision of Service
- ☐ Coordination of Care
- ☐ Evaluation or Assessment
- ☐ Determination of Disability services/benefits
- ☐ Determine need for and/or type of treatment
- ☐ Determination of Medicare, Medicaid or other healthcare
- ☒ Other: Civil Litigation Discovery pursuant to MCR 2.300 and 2.314

The information is to be disclosed to: CD SERVICES INC 24027 Research Drive
Farmington Hills, MI 48335

- I understand that authorizing the disclosure of my record is voluntary and that my services will not be affected if I choose not to sign this form. I also understand that upon request, the information disclosed, pursuant to this Authorization, may be reviewed or copied by the undersigned client/parent/legal guardian as provided in 45 CFR 164.524, the Michigan Mental health Code, 42 CFR Part 2 and other applicable laws, rules and regulations.
- I understand that my alcohol and/or drug abuse treatment records are protected under both federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CFR pts. 160 and 164, and cannot be disclosed without my written permission.
- This information has been disclosed to you from records whose confidentiality is protected by State and Federal Laws which prohibit you from making any further disclosure of this information without the specific consent of the client to whom it pertains or as otherwise permitted by such regulations.
- This authorization, except for action already taken, may be revoked at any time by verbal or written notice to Community Care Services. Without expressed revocation, this authorization expires after one year, or sooner, for any of the following reasons: _____

_____ _____
Consumer/Parent/Legal Guardian's Signature Date Relationship to Client

_____
Witnessed By Date