RELEASE OF CONFIDENTIAL INFORMATION
HIPAA DISCLOSURE

I _____ hereby authorize LADD to disclose and exchange
(My Name- Person Choosing Support Services)
confidential/protected information about me in accordance with the terms and provisions as described below.

1. The name or other specific identification of the person(s) or class of persons, authorized to request, receive and disclose confidential information: ☐ LADD Employees
2. The name or other specific identification of the person(s) or class of persons to whom the requested disclosure may be made:
   - ☐ Contract Agency and Employees: _____
   - ☐ Physicians and other Health Care Professionals _____
     _____
   - ☐ Hospitals/Emergency Medical Technicians _____
   - ☐ Pharmacy _____
   - ☐ Family Members _____
   - ☐ Friend's _____
   - ☐ School _____
   - ☐ Department of Health and Human Services _____
   - ☐ Law Enforcement, Emergency Personnel, Community members; in case of an Emergency_____
   - ☐ Other _____
3. Specific description of the information to be used or disclosed:
   - ☐ Treatment Records and Information: _____
   - ☐ Medical/Health Records: _____
   - ☐ Information on current status of services provided: _____
4. The information may be used or disclosed for each of the following purposes:
   - ☐ Safety and Protection
   - ☐ To provide coordination of care
   - ☐ To obtain benefits and services
   - ☐ To develop natural supports within their community
   - ☐ At the request of the individual
   - ☐ Other (please describe) _____
5. Specify any restrictions regarding the release of information: _____
   _____

Personal statements about this disclosure of confidential/protected information:

- I understand that I may withdraw my authorization at any time by notifying LADD at 300 Whitney Street Dowagiac, MI. 49047 in writing.
- I understand also that such withdrawal of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.
- I understand that some of my Protected Health Information is maintained in an electronic format.
- I understand that, if the person or entity receiving this information is not covered by the Federal Privacy Regulations, such information may no longer be protected from further disclosure.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I also understand that records concerning mental health services I receive are protected by the Michigan Mental Health Code.
- My signature means that I have read this form and/or have had it read to me and explained in language I can understand. I know what information will be disclosed and give my voluntary consent to its release.
- I understand disclosures of Protected Health Information will be made in accordance with the LADD Notice of Privacy Practices.
- I understand that I am responsible to update this disclosure annually and this disclosure is in effect until the new one is received.

_____ _____ _____ _____
My Signature Date My Legal Guardian's Signature Date

_____ _____
Management Signature Date

(A copy of this fully completed and signed form needs to be retained by the person/legal guardian)