AUTHORIZATION FOR RELEASE OF INFORMATION

Rivkin Addiction Medicine, PLLC • Aaron Rivkin, MD
19100 Goddard Road, Suite 1, Allen Park, MI 48101 • Phone/Fax: 313-315-6922

This form authorizes the use and disclosure of your health information as described below.

A. PATIENT INFORMATION

Patient Full Name: _____	Date of Birth: _____
Address: _____	Phone: _____
City, State, ZIP: _____	Medical Record # (if known): _____

B. I AUTHORIZE DISCLOSURE FROM

Rivkin Addiction Medicine, PLLC • Aaron Rivkin, MD • Allen Park, Michigan • Phone/Fax: 313-315-6922

C. I AUTHORIZE DISCLOSURE TO

Select recipient type (check all that apply):

☐	Primary Care Physician	☐	Residential SUD Treatment Program
☐	Psychiatrist / Mental Health Provider	☐	Outpatient Addiction Treatment (IOP / PHP)
☐	Attorney / Legal Representative	☐	Family Member / Caregiver
☐	Other: _____		

Recipient Name / Organization: _____
Address: _____ _____

Phone: _____	Fax: _____

D. INFORMATION TO BE DISCLOSED

Select information to be released (check all that apply):

☐	Complete medical record	☐	Referral documentation
☐	Office visit notes / progress notes	☐	Medication list / prescription history
☐	Laboratory / UDS results	☐	Treatment summary / visit summary
☐	Other: _____		

Date range: From: _____ To: _____	Purpose of disclosure: _____

E. SPECIAL NOTICE: SUBSTANCE USE DISORDER RECORDS (42 CFR PART 2)

IMPORTANT: This practice provides substance use disorder (SUD) treatment. Your SUD treatment records are protected by federal law (42 CFR Part 2), which provides greater privacy protections than standard HIPAA. This section applies if your records include any SUD diagnosis, treatment, or referral information.

By authorizing the release of your records from Rivkin Addiction Medicine, PLLC, you acknowledge and agree to the following:

- Your SUD treatment records may only be used for the purpose stated in this authorization.
- The recipient of your records is prohibited from re-disclosing your SUD records to any other person or entity without your written consent or as otherwise permitted by 42 CFR Part 2.
- Your SUD records may not be used against you in any criminal, civil, or administrative proceeding without a specific court order that meets the requirements of 42 CFR Part 2.
- You may revoke this authorization at any time by submitting a written revocation to Rivkin Addiction Medicine, PLLC, except to the extent that action has already been taken in reliance on this authorization.
- Revoking this authorization will not affect your right to treatment at this practice.

☐	I specifically authorize the release of my substance use disorder treatment records, including any information regarding my diagnosis, treatment, and/or referral for SUD treatment, subject to the protections of 42 CFR Part 2 described above.

F. EXPIRATION

This authorization will expire on (select one):

☐	One year from date of signature	☐	Upon completion of stated purpose
☐	Specific date: _____	☐	Other: _____

G. YOUR RIGHTS AND SIGNATURE

You have the right to refuse to sign this authorization. Refusal to sign will not affect your ability to receive treatment at this practice. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it. A copy of this authorization is as valid as the original.

Patient Signature	Guardian / Representative (if applicable)
X _____	X _____
Printed Name: _____	Printed Name: _____
Date: _____	Relationship: _____
	Date: _____

H. FOR STAFF USE ONLY

Request Received By: _____	Date Records Released: _____