Saginaw Chippewa Indian Tribe

Healing to Wellness

Release of Information

Name: _____ Date of Birth: _____

I Request and Authorize:

- ☐ SCIT Housing
- ☐ SCIT Tribal College
- ☐ Prosecuting Attorney
- ☐ Defense Attorney
- ☐ SCIT Probation Officer
- ☐ Other (specify): _____
- ☐ CMH
- ☐ SCIT Tribal Court
- ☐ Domestic Violence Program
- ☐ SCIT Human Resources
- ☐ SCIT Tribal Police

To Release and/or Exchange Information/Records With:

Saginaw Chippewa Adult Healing to Wellness Court
6954 E. Broadway Road
Mt. Pleasant, MI 48858
Phone: (989) 775-5811 – Fax: (989) 773-9985

You may use or disclose the following information (check all that apply):

- ☐ Identifying information
- ☐ Diagnosis
- ☐ General Progress Report*
- ☐ Discharge summary
- ☐ Treatment plan
- ☐ Current Medications
- ☐ Attendance Report
- ☐ Other (specify) : _____

**Progress report does not include session notes: it is a summary of progress only.*

Reason(s) for Authorization: _____

I understand I have to sign a Release of Information form for the AHTW program to assist me in my well-being and to develop and/or update my case plan.

I understand I may void this authorization in writing and address it to the AHTW staff. If I void this authorization, all information collected prior to being voided will not be affected. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer apply.

I authorize my records be sent to SCIT Adult Healing to Wellness. A Copy of this authorization shall have the same effect as the original.

Print Name: _____ Date signed: _____

Signature: _____ AHTW Initials: _____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER THE DATE THAT IT IS SIGNED