Authorization for the Release and Disclosure of Protected Health Information

MidMichigan Health

Patient Name: ____________________ **Date of Birth:** ____________________

Address: ____________________ **Phone Number:** ____________________

City/State/Zip: ____________________ **Email:** ____________________

I authorize and request that the following organization disclose my protected health information:

- ☐ MidMichigan Health and all its wholly owned subsidiaries
- ☐ ____________________

I authorize that the protected health information should be disclosed to the following organization or individual:

- ☐ ____________________
- ☐ Self
- ☐ Individual/Company/Organization: ____________________

Street Address: ____________________

City/State/Zip: ____________________

Phone Number: ____________________ Fax Number: ____________________

The type and amount of information to be used or disclosed: (Include dates of service)

☐ Consultation Report(s) ______	☐ Discharge Summary ______	☐ Cardiovascular Report(s) ______
☐ History & Physical(s) ______	☐ Emergency Record(s) ______	☐ EKG(s) ______
☐ Laboratory Result(s) ______	☐ Operative Report(s) ______	☐ Pathology Report(s) ______
☐ Hepatitis B Results ______	☐ Newborn Screening Sample ______	☐ Pathology Slide(s) ______

☐ Entire Record or Abstract for: ____________________

☐ X-Ray Report(s) ____________________ ☐ X-Ray Film(s) ______

☐ Other (must be specific) ____________________

☐ Office Notes ____________________

Purpose: *(Not Required)* ☐ Treatment ☐ Payment ☐ Personal ☐ Legal ☐ Transfer of Care ☐ Other

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in CFR 164.524 and MH6 748. I understand that further disclosure shall be consistent with authorized purpose, but any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
  I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at any MidMichigan Health subsidiary.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law providers my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. **If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months from the date signed.**

Indicate the format in which you would like to receive your requested information: ☐ Paper Copy ☐ CD ☐ Portal

____________________ ____________________

Signature of Patient or Legally Authorized Representative ***Date/Time***

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Printed Name of Patient or Legally Authorized Representative

Relationship to Patient:

- ☐ Spouse
- ☐ Parent
- ☐ Next-of-Kin/Executor
- ☐ Legal Guardian
- ☐ DPOA for Healthcare

____________________ ☐ ***Photo ID Verified***

Staff Signature

If you are requesting medical records for someone other than yourself, you may be required to provide documentation that you have a legal right to do so.