



Patient Name \_\_\_\_\_ Maiden / Other Name \_\_\_\_\_  
 Patient Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

- Name of person(s) or organization(s), to whom information is to be released to:  
 Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

- Specific type of information to be disclosed:  
**The authorized person *must initial next to the type of information to be disclosed.***

- \_\_\_\_\_ ER Report                      Date of Service \_\_\_\_\_
- \_\_\_\_\_ Initial Assessment              Date of Service \_\_\_\_\_
- \_\_\_\_\_ Inpatient Summaries              Date of Service \_\_\_\_\_
- \_\_\_\_\_ Medication Evaluation              Date of Service \_\_\_\_\_
- \_\_\_\_\_ X-ray Reports                      Date of Service \_\_\_\_\_
- \_\_\_\_\_ Laboratory Tests                      Date of Service \_\_\_\_\_
- \_\_\_\_\_ Operative Reports                      Date of Service \_\_\_\_\_
- \_\_\_\_\_ Psychiatric Evaluation              Date of Service \_\_\_\_\_
- \_\_\_\_\_ Discharge Summary              Date of Service \_\_\_\_\_
- \_\_\_\_\_ Other – Describe records required and give approximate date(s) of service:  
 \_\_\_\_\_  
 \_\_\_\_\_

- This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.
- This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

Birth Date of Patient \_\_\_\_\_ Social Security Number of Patient \_\_\_\_\_

***Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.***

**Signature of guardian, patient advocate or personal representative** \_\_\_\_\_ **Date** \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Phone Number \_\_\_\_\_