

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:

1. Name of person(s) or organizations(s), to whom disclosure is to be made:

Name _____
Street Address _____
City _____ State _____ Zip _____

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

2. 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 _____
- _____ Medical Evaluation Date of Service _____
- _____ X-Ray Reports Date of Service _____
- _____ CAT Scan Reports Date of Service _____
- _____ MRI Reports Date of Service _____
- _____ Discharge Summary Date of Service _____
- _____ Other- Describe records required and give approximate date(s) of service: _____

3. The purpose and need for such disclosure:

- Evaluation and Treatment Insurance Claim
- Employer Request Attorney Inquiry
- Social Security Consultation
- Workers Comp Continuation of Care
- Other (specify) _____

4. 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.

5. 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 _____

Patient Date of Birth _____ Patient SSN: _____

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 _____ Phone Number _____

Address _____ Witness _____