MUNSON HEALTHCARE
Charlevoix Hospital

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

1. _____ _____
   Patient's Name Date of Birth

2. I authorize _____ to release my protected health information, as I have described below.

3. Date medical care provided _____

☐ Discharge Summary	☐ Lab	☐ Physician's Orders
☐ History & Physical	☐ Imaging (x-ray)	☐ Physician's Progress Notes
☐ ER Record	☐ Physical Therapy	☐ Other: _____
☐ OP Report	☐ EKG/Echo	_____
		_____

4. I request that my protected health information requested above be released or sent to:

   _____
   _____
   _____

5. I am authorizing release of this information for six months from the date of my signature on this form or (write in date you would like authorization to expire) _____. I understand that I may also revoke this authorization by written notification at any time, but that protected health information may have already been released.

6. I understand that once my protected health information is released, the receiving party may redisclose the same information to someone else and that the information may no longer be protected by law.

7. I understand that this authorization includes release of protected health information that may be in my medical record pertaining to drug and/or alcohol treatment, mental health treatment, or diagnosis or history of serious communicable disease such as HIV, AIDS, ARC, or hepatitis.

8. I understand that my continued or future treatment at Munson Healthcare Charlevoix Hospital is not conditional upon my signing this authorization. I may refuse to sign this form and still receive medical treatment at any time.

9. I am requesting release of this information for the following purpose:

☐ To give to another doctor	☐ For my personal records or use
☐ To give to a lawyer	☐ To give to my insurance company
☐ To give to my employer	☐ For another reason (describe): _____
	_____
	_____

10. I have been offered a copy of this authorization and I said: ☐ Yes ☐ No

    _____ _____
    Patient Signature or Personal Representative Signature Date

11. **MEDICAL RECORDS DEPT. USE ONLY:** Verify ID of recipient before relinquishing PHI Records. Circle one of the following:

Driver's License presented	Professional ID presented	Signature match
_____	_____	_____

MHCH employee releasing records: _____