MUNSON HEALTHCARE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please complete all sections below.

Section 1: Patient Information (please print)

Last Name	First Name	Middle Name	Date of Birth (MM/DD/YY)

Home Phone Number	Cell Number	Email address

Street Address	City	State	Zip

Section 2: ***I authorize the designated facility or associated clinic (to encompass, Oncology, Primary care, etc.) to release information contained in my patient records to the individuals or organizations identified for the purposes and conditions designated on this form:***

- ☐ Kalkaska Memorial Health Center
- ☐ Munson Healthcare Cadillac Hospital
- ☐ Munson Healthcare Charlevoix Hospital
- ☐ Munson Healthcare Grayling Hospital
- ☐ Munson Healthcare Manistee Hospital
- ☐ Munson Healthcare Otsego Memorial Hospital
- ☐ Munson Home Health
- ☐ Munson Medical Center
- ☐ Paul Oliver Memorial Hospital
- ☐ Other ______________________________

Section 3: Specific health information to be released or disclosed:

Summary of physician reports & test results for dates of service from:__________ to __________

Complete copy of my Medical Record for dates of service from:__________ to __________(charges may apply)

Other: (please describe) ______________________________

Section 4: What provider/facility should the health information be requested FROM:

Name & address of provider/facility: ______________________________

Name & address of provider/facility: ______________________________

Section 5: To whom is the requested protected health information being released TO: (Select ONE)

☐ **Myself: Paper copy via US Mail** to the address listed in Section 1.

Select other delivery method: ☐ **Pick-up** from the department where I requested the information. ☐ **E-mail (PDF)**

☐ **Fax #** ____________________ ☐ **Other electronic type:** (must be specific) ____________________

☐ **Other:** ***I am the patient, or the legally authorized representative of the patient listed in Section 1 and request the protected health information as indicated on this form be released to:***

Individual/Person Name	Company/Organization

Street Address

City	State	Zip	Phone Number

Select delivery method: ☐ **Fax #** ____________________ ☐ **E-mail** ____________________

☐ **US Mail** ☐ **Other electronic type:** (must be specific) ______________________________

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174,1989) governing HIV, HIV Test, Acquired Immunodeficiency Syndrome (AIDS),and AIDS-related complex (ARC), as well as genetic and demographic information for the purposes and conditions designated within this document.

PATIENT ID LABEL

Continue to page 2

Section 6: Purpose of request/disclosure:

☐ Personal use

Other:(please specify) ______________________________

Section 7: Signature of Patient or Patient Representative

By signing this Authorization, I consent to the disclosure of the information as stated within this document. I understand and agree to the following:

- *I will not hold Munson Healthcare or its associated clinics liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.*
- *I understand that failure to provide all information requested may invalidate this Authorization.*
- *I understand that I may refuse to sign this Authorization and that my health care cannot be conditioned upon signing this Authorization.*
- *I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.*

This authorization will expire one year from the date of signing or otherwise by my choice, in which case this consent will expire on: ________________________.

Date

______________________________ ____________ ____________

Patient Signature **Date** **Time**

______________________________ ____________ ____________

Witness Signature **Date** **Time**

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Relationship to Patient ☐ If patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable

This authorization is subject to a written revocation (cancelling) at any time except in those circumstances in which the Hospital/Facility has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given.

REVOCATION (optional) - This authorization is revoked for the following specified dates, events, or conditions.

Date: ____________ **Event:** ________________________ **Condition:** ________________________

Authorization must be dated subsequent to the service/hospitalization that you are requesting except in cases of ongoing treatments.

INFORMATION RELEASED BY:

____

Name **Position** **Date**

☐ DRIVER'S LICENSE/ IDENTIFICATION VERIFIED, AS APPLICABLE.

PATIENT ID LABEL