

General Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with applicable State and Federal law. **Failure to provide all information requested may invalidate this Authorization.**

Date of Request: _____ Medical Record Number (if known) _____

1. Protected health information may be used or disclosed regarding the following person:

Name: (Last) _____ (First) _____ (M.I.) _____ Date Of Birth _____

Address: (Street/box) _____ (City) _____ (State) _____ (Zip) _____

Telephone: (day) (____) _____ (eve) (____) _____ Social Security #: _____ (Optional)

2. The following person or facility is authorized to *disclose* my Protected Health Information

Name of Person or Facility _____ (Phone) (____) _____

Address: (Street/box) _____ (City) _____ (State) _____ (Zip) _____

3. The following person or facility is authorized to *receive* my Protected Health Information

Name of Person or Facility: _____ (Phone) (____) _____

Address: (Street/box) _____ (City) _____ (State) _____ (Zip) _____

4. My health information will be used or disclosed for the following purpose(s) (ex: Marketing Activities, Fundraising Activities, Employment Determination, Continued Care, Legal, Claims etc.): _____

5. This Authorization applies to the following information*:

- The following records or types of health information (specify date(s) of service): _____
- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Film (avail from Radiology Dept) | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> X-ray Report | <input type="checkbox"/> Cardiopulmonary/EKG Report | <input type="checkbox"/> Multidisciplinary Notes |
| <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Nursing Notes | |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Billing Information (available from Patient Financial Services) |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Laboratory and Pathology Report | |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Other (Please Specify) _____ | |

* Information about the diagnosis and testing for HIV, AIDS, and ARC; Information about alcohol and drug treatment; and Information about mental health services and social services (including communications made to a social worker or mental health professional) may be contained in these documents and will be disclosed if it is part of the requested records. If you do not wish to have this information disclosed, please initial here: _____ .

6. This Authorization expires: _____ (if no expiration date or event is listed, this authorization will expire 90 days after the date of request or at the completion of the request, whichever is earlier)

- If this box is checked, I understand that the person or facility requesting my authorization will receive direct or indirect payment for the uses and disclosures I have authorized.

Signature of Patient or Personal Representative

Relationship to the patient (if Personal Representative)

For Office Use Only: Identity and Authority Validated: _____ (initials) Date Request Received _____

Notice Of Federal And State Laws Regarding Further Disclosure To The Person Or Organization Receiving Information "This information may have been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal regulations (42 CFR, part 2) and State law (Public Act 258, Chapter 7, section 748) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."



Please see Pg. 2 for information on your rights and for mailing information

YOUR RIGHTS:

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this Authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.

I understand that I may revoke this limited Authorization in writing at any time at the address found below, except to the extent that action has been taken in reliance on this Authorization. This Authorization is in effect until revoked by me or until it expires under applicable laws. An exception for registered chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.

This form should be mailed to:

- Saint Joseph Mercy Health System
Health Information Services Department
5301 East Huron River Drive
PO Box 995
Ann Arbor, MI, 48106-0995

- _____

REVOCAION OF THIS AUTHORIZATION

I hereby revoke the authorization made on _____.

Signature of Patient or Representative

Date/Time

Relationship to the patient (if Personal Representative)

This revocation should be mailed to:
Saint Joseph Mercy Health System
Health Information Services Department
5301 East Huron River Drive
PO Box 995
Ann Arbor, MI, 48106-0995