ST. MARY'S OF MICHIGAN

800 S. WASHINGTON AVE.
SAGINAW, MICHIGAN 48601
**PHONE: 989-907-8081**
**FAX: 989-907-8697**

patient label

MR#_____

# HIPAA AUTHORIZATION FOR THE USE OF DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____
Last First Middle Date of Birth

Address: _____ (____)_____
Street City State Zip Telephone

1. **RELEASE INFORMATION FROM**: By signing below, I hereby authorize _____ _____ (provider, healthcare organization, clinic, facility, etc.) to release information contained in my medical record (protected health information).
2. **RELEASE INFORMATION TO**: I authorize the above to release the protected health information defined below to _____
(provider, healthcare organization, clinic, facility, etc.)
3. **WHAT SHOULD BE RELEASED:**

☐ MY ENTIRE MEDICAL RECORD(S) ☐ MY MEDICAL RECORD FOR THE DATES: _____

☐ ONLY THESE SPECIFIC DOCUMENTS: _____

4. I am requesting that the information be released for the following purpose(s):

☐ CONTINUED MEDICAL CARE ☐ LEGAL MATTER ☐ PAYMENT ☐ OTHER

5. I understand that the records to be disclosed may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse.
6. Expiration Date: ☐One year after the date signed ☐ Other_____
7. I understand that I have the right to revoke this Authorization, EXCEPT:
   - If the information authorized to be released has already been released, or
   - If this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
8. I understand that I may revoke this Authorization by sending a written request to the attention of the Privacy Officer at the organization releasing this information.
9. I understand that once the information is released in accordance with this authorization, the information may be redisclosed by that party, and the privacy of my Protected Health Information may no longer be protected by the law.
10. I understand that there may be a fee associated with this request. If there is a fee, I expect the organization to contact me before copies are made.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____
Printed Name of Person Signing Relationship to Patient

☐ ID Verified

_____
Witness Date

White: Medical Record