

**AUTHORIZATION FOR USE AND/OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Job #: _____
MR #: _____
ID Checked: <input type="checkbox"/> Initials: _____

Information About the Use or Disclosure

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below:

Individual's Name: _____
(Print or type full name)

Previous Name: _____ Date of Birth: ____/____/____
 Address: _____ Day Phone #: (____)____-____
 City, State Zip: _____ Evening Phone #: (____)____-____

Persons/organizations authorized to release the PHI:	Persons/organizations authorized to receive the PHI:
Portage Health Name of Person/Organization to Release PHI	Portage Health Medical Group Name of Person/Organization to Receive PHI
500 Campus Drive Address	500 Campus Drive Address
Hancock, MI 49930 City, State, Zip	Hancock, MI 49930 City, State, Zip
(906) 483-1554 Medical Records Phone #	(906) 483-1536 Medical Records Fax #
	Phone #: (____)____ Fax#: (____)____

Specific description of PHI to be used or disclosed (please check all that apply): _____

<u>Hospital Records:</u>	<u>Date</u>	<u>Physician Office Records:</u>	<u>Date</u>
ED <input type="checkbox"/>	____/____/____	M.D. Visit Note <input type="checkbox"/>	____/____/____
Discharge Summary <input type="checkbox"/>	____/____/____	Medication List <input type="checkbox"/>	____/____/____
Operative Report <input type="checkbox"/>	____/____/____	Problem List <input type="checkbox"/>	____/____/____
Lab(s) <input type="checkbox"/>	____/____/____	Immunization Record <input type="checkbox"/>	____/____/____
X-ray(s) <input type="checkbox"/>	____/____/____	Referral Report <input type="checkbox"/>	____/____/____
Inpatient Record <input type="checkbox"/>	____/____/____	Lab(s) <input type="checkbox"/>	____/____/____
Other (specify) <input type="checkbox"/>	____/____/____	X-ray(s) <input type="checkbox"/>	____/____/____
		Other (specify) <input type="checkbox"/>	____/____/____

I specifically mean this to include any information regarding HIV/AIDS, Drug or Alcohol use/abuse, Mental Health and other records in accordance with federal regulations. Please cross out any that do not apply.

Specific purpose of the disclosure (please check one):

- Continuing care Insurance Legal Personal
 Other: _____

This authorization will expire: One (1) year from the date of your signature below _____
 [Indicate a date (e.g., December 31, 2010) or an event relating to the purpose of the authorization (e.g., "rejection of my life insurance application")]

Important Information About Your Privacy Rights:

I have read and understood the following statements about my privacy rights:

- * I may revoke this authorization at any time prior to its expiration date by notifying the Director of Medical Records in writing, but the revocation will not have any effect on any actions Portage Health System took in Reliance on this authorization before it received my revocation.
- * I may request a copy of this authorization from the provider. The provider must provide me with a copy of my signed authorization.
- * The provider may not require you to sign this authorization in order for you to receive treatment.
- * Information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

_____/____/____
 Individual's Signature Date

If the authorization is being signed by a personal representative of the individual (such as a parent of a child under the age of 18):

_____/____/____
 Type/Print Name of Personal Representative Personal Representative's Signature Date