AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Job #: _____

MR #: _____

ID Checked: ☐ 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:**
_____ Name of Person/Organization to Release PHI	Portage Health Name of Person/Organization to Receive PHI
_____ Address	500 Campus Drive Address
_____ City, State, Zip	Hancock, MI 49930 City, State, Zip
Phone #: ( ) Fax #: ( )	Phone #: (906) 483-1554 Fax #: (906)483-1536

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

Hospital Records:		**Date**	**Physician Office Records:**		**Date**
ED	☐	____/____/____	M.D. Visit Note	☐	____/____/____
Discharge Summary	☐	____/____/____	Medication List	☐	____/____/____
Operative Report	☐	____/____/____	Problem List	☐	____/____/____
Lab(s)	☐	____/____/____	Immunization Record	☐	____/____/____
X-ray(s)	☐	____/____/____	Referral Report	☐	____/____/____
Inpatient Record	☐	____/____/____	Lab(s)	☐	____/____/____
Other (specify)	☐	____/____/____	X-ray(s)	☐	____/____/____
			Other (specify)	☐	____/____/____

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