McLaren NORTHERN MICHIGAN

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name (First Name) **(Middle Initial)** **(Last Name)** **Medical Record Number**

Date of Birth **Maiden Name** **Telephone Number**

I authorize McLaren Northern Michigan Hospital (MNM) to release my health information to:

Person or Agency Health Information To Be Released To

Address City/State Zip

Specific Health Information I Authorize For Release

Visit Date(s):

- ☐ Record Abstract ***(includes all dictation and test results)***
- ☐ Discharge Summary
- ☐ History & Physical ☐ Emergency Room Report
- ☐ Operative Report ☐ Pathology
- ☐ Cardiology ☐ Dictated Report ☐ Films – will be provided in the form of a CD
- ☐ Radiology ☐ Dictated Report ☐ Films – will be provided in the form of a CD

Specify Exam:

- ☐ Laboratory
- ☐ Drug &/or Alcohol Results
- ☐ Other (please specify): _____
- ☐ Complete Copy of My Medical Record
  - ***(Payment is required in full prior to the release of a complete medical record)***

This Authorization Is Provided For The Purpose Of: (only check one)

- ☐ My treatment by another health care provider
- ☐ Legal purposes
- ☐ Determine eligibility for enrollment in a health plan or program (e.g., disability claim, workman's comp, etc.)
- ☐ Billing/Insurance questions
- ☐ Application for employment
- ☐ Medical or clinical trial research
- ☐ Other (please specify): _____
- ☐ At my request

Medical Record Copy Charges – To be completed by MNM

Records sent directly to a care provider will be processed free of charge. All other requests will be charged a fee as outlined below.

	Fee Schedule	Total Pages and/or CD Copied	Total Charges For This Release
1-20 Pages	$1.16 per page		$
21-50 Pages	$0.58 per page		$
51 or more pages	$0.23 per page		$
CD (images only)	No Charge		n/a
			$

MNM 768.111 – R (2-20-2013)

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Patient or legal representative initials are required for each section below

PLEASE READ AND INITIAL LINES 1 – 8:

I understand that, unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, HIV, AIDS or ARC.

1. _____ **Clause for sensitive information release (Psych, Substance, STD)**

2. _____ This authorization is made in accordance with Federal and State law and is valid for a period of no more than six months after being signed or until (specify date) _____/_____/_____.

3. _____ I understand that I may revoke this authorization at any time except to the extent McLaren Northern Michigan Hospital has taken action in reliance on the authorization. A written revocation may be sent to: McLaren Northern Michigan Hospital, 416 Connable Ave., Petoskey, MI 49770, Attn: Privacy Officer.

4. _____ I understand that once my health information is used or disclosed pursuant to this authorization, it may be re-disclosed or released by the Receiving Party and may no longer be protected by Federal or State law.

5. _____ I understand that my continued or future treatment by McLaren Northern Michigan Hospital is not conditional upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.

6. _____ I understand that I have the right to inspect or copy the health information McLaren Northern Michigan Hospital intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

7. _____ I understand that my authorization of the use or disclosure of my health information as indicated in this document may allow for financial gain.

8. _____ I understand that I may request a copy of this authorization for my records at no charge.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

	/ /	
Signature of Patient	Date	Time (AM/PM)
	/ /	
-OR- Signature of Legal Representative & Relationship to Patient **(Required)**	Date	Time (AM/PM)

Copy of legal documentation must be attached when other than custodial parent

	/ /	
Witness to signature ***(Required to be signed by an MNM Colleague)***	Date	Time (AM/PM)

Request Processed by (signature): Date: _____/_____/_____ Time: