

MARQUETTE GENERAL HEALTH SYSTEM

MARQUETTE, MICHIGAN

Medical Record #: _____

(Office Use Only)

Authorization To Release Protected Health Information

(Required items are in **BOLD** print)

Patient Name: _____ **Birth Date:** ____/____/____

Previous Names: _____ **Social Security #:** ____/____/____

Address: _____ **City, State & Zip Code:** _____ **Phone #:** _____

I, _____ authorize _____
NAME OF PATIENT OR NAME OF LEGAL REPRESENTATIVE *NAME OF ORGANIZATION / PROVIDER TO RELEASE INFORMATION*

to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

<i>NAME/ORGANIZATION TO RECEIVE INFORMATION</i>	<i>Phone Number</i>
<i>Address</i>	<i>City, State and Zip Code</i>

1. **Specific information to be disclosed (check all that apply)**

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology/X-ray Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> EKG/Stress Test | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> Operative/Procedure Reports |
| Other: _____ | | | <input type="checkbox"/> Home Health |

For the following date(s) of treatment or medical conditions: _____

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: _____

3. **I am requesting this information be released for the following purpose:**

- Continued Care Insurance Claim Personal Use Attorney Review
 Other _____

4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand there may be a fee to process this release of information.

6. This authorization will automatically expire on: ____/____/____ or one year from the date of my signature.

7. Marquette General Health System will not condition my continued treatment upon my signing this authorization, except for research-related treatment.

8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.

9. I hereby agree to indemnify and hold Marquette General Health System, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

Patient or Patient's Legal Representative's Signature

Date

**Relationship If Other Than Patient*

Witness

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____

* **AUTHORITY ATTACHED** (In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization).

Hold for future information request