deckerville COMMUNITY HOSPITAL

3559 PINE ST.
DECKERVILLE, MI 48427
PHONE: 810.376.2835
FAX: 810.376.4978
DECKERVILLEHOSP.ORG

PATIENT STICKER

Authorization for Release of Patient Information

LAST NAME: _____ FIRST NAME: _____ BIRTH DATE: _____

PHONE NUMBER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I hereby authorize **DECKERVILLE COMMUNITY HOSPITAL**, to use or disclose my protected health information and records concerning my health condition(s) as indicated via

☐MAIL ☐FAX ☐CD ☐E-SUBMISSION (i.e: E-mail/EMR sharing) ☐PHONE ☐PERSONAL PICK UP

To the below physician, individual and/or facility:

NAME(S): _____

PHONE NUMBER: _____ FAX NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RESTRICTIONS: Only medical records that have originated through this healthcare facility will be photocopied. This authorization is valid only for the release of medical information dated prior to and including the date patient or legal guardian signed the authorization. I understand the information in my health record may include information relating to sexually transmitted diseases, AIDS, HIV, behavioral and mental health services, and treatment for alcohol and or substance abuse.

Information to be released:

- ☐ Laboratory: Date(s)_____
- ☐ Radiology: Date(s)_____
- ☐ ER Record: Date(s)_____
- ☐ OP Procedure: Date(s)_____
- ☐ WIC Record: Date(s):_____
- ☐ Surgical Record: Date(s):_____
- ☐ Office Notes: Date(s):_____
- ☐ Other: _____

Purpose of Disclosure:

- ☐ At Patient Request
- ☐ Continuation of Medical Care
- ☐ Changing Physicians
- ☐ Insurance
- ☐ Workers' Compensation
- ☐ School
- ☐ Second Opinion
- ☐ Legal
- ☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I realize that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

By signing below, I acknowledge that I have read and understand this Authorization for Use or Disclosure of Protected Health Information.

_____ _____ _____

Signature of Patient or Authorized Person ***Relationship*** ***Date***

_____

Witness

Processed By:
HIM *LAB* *X-RAY* *NURSING* *DHS*

SIGNATURE: _____ Date: _____

Reason for Unprocessed Release: Initial/Date:_____

- ☐ *Missing Patient Information*
- ☐ *Missing Authorized Signature*
- ☐ *Missing Where to Release / What to Release*
- ☐ *Other:* _____