Helen Newberry Joy
Hospital & Healthcare Center
502 West Harrie Street, Newberry, MI 49868

MR # / ACCT #_____
Logged_____
Bill #_____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Patient's Name:

(please print clearly) Previous Name: _____ Address: _____ City, State, Zip: _____	Date of Birth: _____ Day Phone: ( )_____ Evening Phone: ( )_____
Authorized to: (*please circle your choice*) **RELEASE** or **RECEIVE** the Personal Health Information **Please check all that apply:** ☐ Helen Newberry Joy Hospital ☐ Gibson Family Health Center (all providers) ☐ Dr. Beaulieu ☐ Dr. Gill ☐ Dr. Rao ☐ Other_____ ☐ Dr. Webb ☐ Manistique Lakes Family Clinic _____ ☐ West Mackinac Health Clinic ☐ Gibson 2nd Floor _____ ☐ Surgical Suite_____	Authorized to: (*please circle your choice*) **RELEASE** or **RECEIVE** the Personal Health Information Name _____ Address _____ City _____ State _____ Zip _____ Phone # _____ Fax # _____
502 W. Harrie Street Newberry, MI 49868 Health Information Phone # (906) 293-9236 Health Information Fax # (906) 293-3753	I authorize the disclosure of my healthcare record as described below, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency or abuse, psychological or social service records, or any such related information.
Information to be released (*please check all that apply*) **Hospital Records:** **Dates of Service/Range:** ☐ _____ ED ☐ _____ Lab(s) Report ☐ _____ X-ray(s) Report ☐ _____ EKG / Stress Test / Echo / Holter / Sleep Study / PFT ☐ _____ Operative / Procedure Report ☐ _____ Inpatient Record ☐ _____ H&P / Progress Note(s) / Discharge Summary ☐ _____ Nursing Records ☐ _____ Other: _____	**Information to be released** (*please check all that apply*) **Clinic or Physician Office Records:** **Dates of Service/Range:** ☐ _____ Office Note / T-Sheet /Progress Note ☐ _____ Discharge Instructions ☐ _____ Physical ☐ _____ Medication List / Problem List / Medical Summary ☐ _____ Immunization Record ☐ _____ Lab(s) Report ☐ _____ X-ray(s) Report ☐ _____ Referral Reports / Consultations ☐ _____ Other: _____

Purpose of the disclosure *(please check one)*: ☐ Continuing Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other: _____

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 Health Information Management Director in writing, the revocation will not have any effect on any actions taken prior to the revocation.
- I may request a copy of this signed authorization from the Health Information Management Department.
- I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- I understand there may be a fee to process this release of information.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
- This authorization will expire in 6 months from the date of execution or upon the following date or event: _____

_____ _____ _____ _____
Signature of Patient or Patient's Legal Representative* Date Witness Signature Date

*If authorization is being signed by a personal representative of the individual, documentation of their authority to act must be provided.