

HELEN NEWBERRY JOY HOSPITAL & HEALTHCARE CENTER
502 W. Harrie Street Newberry, MI 49868 (906) 293-9200

MEDICAL INFORMATION RELEASE AUTHORIZATION

Patient Name	Maiden Name
Address	Birthdate
Telephone Number	Medical Record Number

1. I hereby authorize _____ (name of health care provider) to disclose my individually identifiable health information 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, psychological or social service records, or any such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. 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.
2. The health information described herein shall be released to: _____ Hospital _____ Physician _____ Insurance Company _____ Attorney _____ Patient _____ Other (check appropriate category)

Name	Address	City	State	ZIP	Phone Number
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3. Purpose and need for such disclosure: _____

4. Description of information to be released (check all that apply and provide dates of service or range of dates):

<u>Document</u>	<u>Date of Service</u>	<u>Document</u>	<u>Date of Service</u>
<input type="checkbox"/> Emergency Room	_____	<input type="checkbox"/> H&P	_____
<input type="checkbox"/> Discharge Summary	_____	<input type="checkbox"/> Consultation Reports	_____
<input type="checkbox"/> Operative Procedure Records	_____	<input type="checkbox"/> Xray Reports	_____
<input type="checkbox"/> Laboratory Reports	_____	<input type="checkbox"/> Xray Films	_____
<input type="checkbox"/> Progress Notes	_____	<input type="checkbox"/> Nurses' Notes	_____
<input type="checkbox"/> Physician Notes	_____	<input type="checkbox"/> Billing Records	_____
<input type="checkbox"/> EKG/Stress Test/Echo	_____	<input type="checkbox"/> Other (Specify)	_____
<input type="checkbox"/> Psychological/Substance Abuse Evaluation	<i>Federal Regulations (42 CFR and Public Act 258)</i>		

5. I understand that upon request, I may inspect or request copies of the above-described protected health information to be used and/or disclosed.
6. I understand this authorization will expire in 6 months from the date of execution or upon the following date or event: _____. However, it may be revoked by me at any time by providing notice in writing to the above named party. The revocation must be dated with a date that is later than the date on this authorization and signed. The revocation will not affect any actions taken before receipt of the revocation.
7. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law.
8. HNJH & Healthcare Center will provide the patient or representative with a copy of this authorization upon request. _____ (Initial)

Signature of Patient or Patient's Legal Representative*	Date
Relationship to Patient	Signature of Witness

This patient is unable to provide written authorization because: _____

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

___Authority attached

Records released by: _____ Date: _____