Ascension Michigan

Patient Full Name _____ Maiden / Other Name _____

Patient Address _____
Street City State Zip

Patient Date of Birth _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____hereby authorize **Ascension Michigan,** its Director or Designee, or Health Information Management/Medical Records Department ("Ascension Michigan"), to release the protected health information described below (**"PHI"**). The PHI may include information about: alcohol and drug abuse treatment (protected by the Federal "Part 2 Regulations"); behavioral or mental health services; and/or communicable diseases and infections, such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

1. Name of person(s) or organization(s), to whom the PHI is to be released to:

   Name _____
   Street Address _____
   City_____ State_____ Zip Code _____

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy may no longer be protected by the law.

2. The purpose of the use or disclosure is:
   - ☐ For_____; **OR**
   - ☐ At my request

3. The following PHI is to be disclosed:
   Initial **next to the type of record to be disclosed.**

Type of Record	Date(s) of Service
_____ER Report	_____
_____Initial Assessment	_____
_____Inpatient Summaries	_____
_____Medication Evaluation	_____
_____X -ray Reports	_____
_____Laboratory Tests	_____
_____Operative Reports	_____
_____Psychiatric Evaluation	_____
_____Discharge Summary	_____
_____Entire Medical Record	_____
_____Office Records	_____
_____Immunization Records	_____

_____Other – Describe records required and give approximate date(s) of service:

_____

_____

4. This Authorization may be revoked at any time, by writing to Ascension Michigan at: _____, except to the extent that information has already been released or disclosed.
5. Ascension Michigan does not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based upon this Authorization or its revocation.
6. This Authorization will expire (select one):
   - ____ When the purpose for the use or disclosure (as specified in Section 2) has been achieved.
   - ____ Upon ninety (90) days after the date signed below.
   - ____ On _____[date].

Signature of Patient_____**Date** _____

If patient is incapable or is a minor, signature of parent, guardian, patient advocate or personal representative is required.

Name: _____

Signature _____ Date_____

Relationship_____

Address _____

Phone Number_____

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