CORRESP

Ascension Genesys Hospital

One Genesys Parkway, Grand Blanc, MI 48439-8066
Phone: 810-606-5000

DEPARTMENTAL USE

Medical Record # __________________

Account # ________________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: ____ Birth Date:____________________

Patient's Address:____ Social Security #: ______________

City/State/Zip:____

Maiden/Other Names: ____ Telephone #: __________________

1. I authorize Ascension Genesys Hospital or ___________________________________to use and disclose protected health information contained in the patient record indicated above, including as applicable:
   - Communicable disease and infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC") and (specify other, if known) __ ____
   - Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
   - Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.
2. Name and address of person or organization to whom disclosure of my protected health information is to be made; ____
3. This authorization shall expire 120 calendar days from the date of signature or upon completion of this request.
4. I understand that I may revoke this authorization by contacting Medical Records at 810-606-5619 and requesting an Authorization Revocation form to fill out and return.
5. I understand that the right to revoke this Authorization, is not approved if:
   - Ascension Genesys Hospital has taken action in reliance upon this Authorization; or,
   - If this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
6. I understand that my protected health information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my protected health information will no longer be protected by the law.
7. Specific type of information to be disclosed (include dates and type of treatment): ____________________________ ____
8. The purpose and need for disclosure:____

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

______________________________________ ______________________________________

Signature (Patient) Date Signature (Authorized Representative) Date

______________________________________ ______________________________________

Printed Relationship of Authorized Representative

____

Signature (Witness) Date

GIVE A COPY OF THE SIGNED AND DATED AUTHORIZATION TO THE INDIVIDUAL.

KEY FOR THE USE AND COMPLETION OF AUTHORIZATIONS FOR RELEASE OF PROTECTED HEALTH INFORMATION.

Commentary:
This authorization is to be used for all ***Uses*** and ***Disclosures*** of ***Protected Health Information (PHI)*** for purposes other than ***Treatment, Payment*** or ***Health Care Operations***. 45 C.F.R. § 164.501 gives the definition of each of these functions. (*See* Glossary, G.57, G.39 and G.21 of the Privacy Standards Manual.)

Situations in which you should use this authorization are those in which the ***Individual*** initiates the authorization or another person requests the ***Use*** of ***Disclosure*** of the ***PHI***. Examples of the need to use this type of authorization include:

- An ***Individual*** requests ***Disclosure*** of his ***PHI*** to a prospective employer.
- An ***Individual*** applies for life or disability insurance and agrees to the ***Disclosure*** of her ***PHI*** to the insurance company.
- An attorney seeks the ***Health Information*** of a client to evaluate an injury claim.

1. Add the name or other specific identification of the person or class of persons authorized to make the requested ***Use*** or ***Disclosure***. If you intend to permit a class of ***Covered Entities*** to disclose information to an authorized person, the class must be stated with sufficient specificity so that a ***Covered Entity*** presented with the authorization will know with reasonable certainty that the ***Individual*** intended the ***Covered Entity*** to release ***PHI***. For example, listing "all physicians" as being authorized to disclose ***PHI*** does not provide a licensed nurse practitioner presented with the authorization with reasonable certainty that the ***Individual*** intended for the LPN to be included in the authorization.

2. Add the name or other identification of the person or class of persons to whom you may make the requested ***Use*** or ***Disclosure*** with sufficient specificity to reasonably permit a ***Covered Entity*** responding to the authorization to identify the authorized user or recipient of the ***PHI***.

3. Add a determinative expiration date (e.g., January 1, 2001), a specific time period (e.g., one year from the date of signature), or an event directly relevant to the ***Individual*** or the purpose of the ***Use*** of ***Disclosure***.

4. The authorization must include instructions on how the ***Individual*** may revoke the authorization. For example, the authorization can include an address where the ***Individual*** can send a written request for revocation.

5. The inclusion of this statement is required by law.

6. The inclusion of this statement is required by law.

7. Indicate the specific type of information, include dates and type of treatment, to be disclosed. The description must include sufficient specificity to allow you to know which information the authorization references. For example, the description may be "laboratory results from July 1998" or "all laboratory results" or "results of MRI performed in July 1998." There are no limitations on the information that can be authorized for ***Disclosure***; therefore, the entire medical record can be disclosed if the authorization so specifies by saying, for example, "all ***Health Information***."

8. Indicate the purpose and need for the disclosure.

Signature: Verify the ***Individual's*** identify or authentication of the ***Individual's*** signature, via photo ID, or comparison of signature in the record.

Date: The date on which the authorization is signed by the ***Individual*** is required.

Signature by Authorized Representative: If the authorization is signed by an authorized legal representative of the ***Individual,*** the representative must indicate his or her authority to act for the ***Individual***. Obtain a copy of any legal document.

Signature (Witness):/Date: Witness signature and date of the request is required.

GIVE A COPY OF THE SIGNED AND DATED AUTHORIZATION TO THE INDIVIDUAL.