ST. JOSEPH HEALTH SYSTEM
TAWAS CITY, MICHIGAN

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ _____ to release the following information from the medical record(s) of:

_____

Patient Name | Date of Birth | Social Security Number

_____

Address | City | State | Zip

Including information about communicable disease and serious communicable disease and infection, including alcohol and drug abuse, psychological and social services records as defined by statue and Michigan Department of Public Health rules (42 Code of Federal Regulations Part 2) which include venereal disease "VD", tuberculosis "TB", Hepatitis, Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS related complex "ARC", which are covered under Section 1910.1030 of the Federal Register, if any, to the individuals or organizations listed below, only under the conditions listed below:

To: **St Joseph Pediatric Clinic, 110 Beech St., Suite A, Tawas City, MI. 48763**
(989)984-3770 (phone) (989)984-0038 (fax)
Covering the date(s): _____

Specific information to be released: _____

Purpose of Disclosure: _____

I understand that if the person(s) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release St Joseph Health System (SJHS), its employees and my physicians from all liability arising from this disclosure of my health information to the extent indicated and authorized herein.

I understand that I may inspect or request copies of any information disclosed by this authorization.

I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request. I understand that this authorization will expire three (3) months from the date of signing, or earlier for any of the specified dates, events or conditions:

_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment,or my eligibility for benefits. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

St. Joseph Pediatrics will provide the Patient or Representative with a copy of the signed authorization upon request.

Signed: _____ _____ _____
Patient Representative | Relationship | Date

Witness: _____ Records Sent (Date) _____ Initials _____