GENESYS | ST. MARY'S OF MICHIGAN | ST. JOSEPH HEALTH SYSTEM | ST. MARY'S OF MICHIGAN STANDISH HOSPITAL

One Genesys Parkway, Grand Blanc, MI 48439-8066
800 S Washington, Saginaw, MI 48601
200 Hemlock, PO Box 659, Tawas City, MI 48764-065
805 W. Cedar St., Standish, MI 48658

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to release the following information from the medical records of:

_____

Patient Name (Please Print) **Date of Birth** **MRN#**

_____

Address **Visit #**

_____

Maiden/Other Names Telephone #

Including information 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.

Release To: _____

Name and Address of person(s) or organization(s) to whom information is to be released

Release (please choose appropriately below)

- Only these specific documents _____
- Medical records for the dates of: _____

✓ 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 Genesys, St. Mary's of Michigan, St. Mary's of Michigan Standish and St. Joseph Health Systems, 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 Health Information Management Department, knowing that previously disclosed information would not be subject to my revoked request. I understand that this authorization will expire sixty (60) days from the date of signing, or earlier for any of the specified dates, events, or conditions.

_____

✓ I understand that there may be a fee associated with this request. If there is a fee, I expect the organization to contact me before copies are made.

✓ 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.

_____ _____

Signature of patient Date Signature (Authorized Representative) Date

All areas must be complete for this form to be a valid request. If submitting by mail, please include a copy of your ID or DL

ID Verified _____ Date Released _____ Initial/sign: _____