McLaren
PORT HURON
1221 Pine Grove, Port Huron, MI 48060

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, waive all Hospital-Physician/Patient privilege respecting hospital Medical information and hereby authorize _____ its Director or Designee, or Health Information Services Department, to release protected health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about, suspected child abuse, behavioral or mental health services and treatment for alcohol and drug abuse as defined by MCLA 333.5131and Title 42 Code of Federal Regulations, Part 2. I understand that signing this authorization is voluntary, i.e. my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
This authorization can be revoked, in writing, at any time except when the information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved. **This authorization expires automatically ninety (90) days from the date signed below or when the purpose of the disclosure has been achieved, whichever is later.**

I UNDERSTAND THERE COULD BE A FEE FOR COPIES OF MY MEDICAL RECORDS.
PATIENT SHOULD PLEASE INQUIRE BEFORE REQUESTING COPIES
Allow 7-10 business days for receipt of copies

Name of Patient: _____ Patient Date of Birth: _____

Address of Patient: _____ Phone: _____

Last four digits of Social Security Number: __ __ __ __ **MR #** of Patient: _____ **DOS** _____

E-mail Address: _____

☐ **I am the Patient.**

☐ **I am the Personal Representative of the Patient <u>because</u>,** (initial one)
_____ I am the patient's custodial parent*
_____ I am the patient's legal guardian **
_____ I am the patient's Patient Advocate and ALL conditions necessary for making this designation effective, have occurred **

☐ **The Patient is deceased** (initial one): (refer to PHH instructions for releasing deceased patient records)

_____ I have been LEGALLY appointed executor or administrator of the estate <u>(Letter of Authority required)</u>
_____ I am the patient's heir-at-law including, but not limited to his or her spouse <u>(Heir-at-Law statement completed)</u>
_____ I am the beneficiary of the patient's life insurance policy. **<u>NOTE:</u>** Medical record information is <u>released directly to the Insurance Company</u>

*** EVIDENCE OF RELATIONSHIP MAY BE REQUIRED ** COPY OF RELEVANT DOCUMENTS ATTACHED**

<u>Disclose To:</u> Name: _____
Organization: _____
Address: _____
City/State/Zip: _____ Fax No._____

By signing this Authorization, I hereby request and authorize that McLaren Port Huron, its agents and employees to release the following <u>Protected Health Information **(PHI)**</u>**:**

_____

I AUTHORIZE _____**TO PICK UP MY MEDICAL RECORDS.**

Signed: _____ **Date/Time**: _____
(*Circle One*) Patient\ Legal Guardian \ Personal Representative

Witness Signature: _____ **Date/Time:** _____

Release of Information

ROI, Form #396, Rev. 11/14

<u>STAFF ONLY</u>
<u>Method information was disclosed:</u>
Mail ____ Fax_____ Pick up _____ E-mail _____
ID verified _____ (picture ID required)
Request completed by: (initials) _____ date: _____ time: _____