HURON MEDICAL CENTER
Authorization for Use or Disclosure of Information

Patient Name:_____ Date of Birth:_____ Telephone No.:_____

Address:_____
Street City State Zip

Recipient Name:_____ Telephone No.: _____

Address:_____
Street City State Zip

I hereby authorize Huron Medical Center to use or disclose the following protected health information for services rendered on _____
Date

- ☐ Complete Copy of Chart
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Other:_____
  Include specific description and/or any date of service limitations.
- ☐ Emergency Room Reports
- ☐ Consultation Records
- ☐ Radiology Reports
- ☐ Laboratory/Pathology Reports

Purpose of disclosure:

_____

If for patient's own purposes, the purpose may be described as "at the patient's request".

I UNDERSTAND THAT:

- The information used or disclosed pursuant to this Authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and AIDS Related Complex (ARC), as well as any medical records relating to alcohol, drug, and mental health treatment information.
- Except to the extent that Huron Medical Center has taken any action in reliance upon this Authorization, I may revoke this authorization, in writing, at any time by sending written notice of revocation to: Director of Medical Records, 1100 S. Van Dyke, Bad Axe, MI 48413.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this Authorization and understand that Huron Medical Center will not condition my treatment on whether I provide authorization.
- If this Authorization permits the disclosure of records and information concerning treatment that I will receive that is research related, or is provided solely for the purpose of creating health information for a third party, then such treatment may be conditioned upon my signing of this Authorization.
- I have the right to inspect or copy the protected health information used or disclosed as permitted by applicable law.
- A photo reproduction of this Authorization shall be as valid in all respects as the original.

This Authorization will expire at the later of _____ or 180 calendar days.
(Date or Event)

_____ _____
Signature of Patient/Parent/Guardian/Personal Representative Date

_____
Printed Name of Patient/Parent/Guardian/Personal Representative
(Please provide a copy of proof of Guardian/Personal Representative status)

☐ Records Given to Patient: _____ ☐ Records to be Picked Up / Mailed: _____
Date (circle choice) Date

A copy of this signed form will be provided to the patient.