McLaren
CARO REGION

P.O. BOX 435, 401 N. HOOPER ST.
CARO, MICHIGAN 48723-0435

Authorization for Use or Disclosure of Information

Patient Name: _____ Date of Birth: _____ Med. Rec. No._____

Address: _____
Street *City* *State* *Zip*

Recipient Name:_____ Telephone No.: _____ Fax No.: _____

Address: _____
Street *City* *State* *Zip*

I hereby authorize _____ to use or disclose the following protected health information for services rendered on _____ (date)

- ☐ Complete Copy of Chart
- ☐ Emergency Room Reports
- ☐ Operative Report
- ☐ Laboratory/Pathology Reports
- ☐ History & Physical
- ☐ Physician Notes
- ☐ Consultation Records
- ☐ Radiology Report

Other:_____
Include specific description and/or any date of service limitations.

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 McLaren Caro Region has taken any action in reliance upon this Authorization, I may revoke this authorization, in writing, at any time by sending written notice or revocation to: Heather McAllister, Privacy Officer.
- 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 McLaren Caro Region **will not** condition continued or future treatment on whether I provide authorization. **However**, treatment **will** be conditioned on signing this Authorization if my treatment is research related or is being provided solely for the purpose of creating health information for a third party.
- I have the right to inspect or obtain a copy of 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 in twelve months, unless otherwise specified. Expiration Date: _____
- If the patient is under the age of 18, a parent or guardian's signature is required.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship of Personal Representative to Patient
(Please provide a copy of proof of Personal Representative Status)

_____ _____
Witness Date

Insurance _____ Charges _____