



3559 Pine Street - PO Box 126 | Deckerville, MI 48427-0126 | (810)376-2835 | www.deckervillehosp.org

Authorization for Release of Patient Information

LAST NAME: FIRST NAME: BIRTH DATE:
PHONE NUMBER: ADDRESS:
CITY: STATE: ZIP CODE:

I hereby authorize DECKERVILLE COMMUNITY HOSPITAL, to use or disclose my protected health information and records concerning my health condition(s) as indicated via

- MAIL FAX CD E-SUBMISSION PHONE PERSONAL PICK UP
(i.e: E-mail/EMR sharing)

To the below physician, individual and/or facility:

NAME(S):
PHONE NUMBER: FAX NUMBER:
ADDRESS: CITY: STATE: ZIP:

RESTRICTIONS: Only medical records that have originated through this healthcare facility will be photocopied. This authorization is valid only for the release of medical information dated prior to and including the date patient or legal guardian signed the authorization. I understand the information in my health record may include information relating to sexually transmitted diseases, AIDS, HIV, behavioral and mental health services, and treatment for alcohol and or substance abuse.

Information to be released:

- Laboratory: Date(s) OP Procedure: Date(s) Office Notes: Date(s)
Radiology: Date(s) WIC Record: Date(s) Other:
ER Record: Date(s) Surgical Record: Date(s)

Purpose of Disclosure:

- At Patient Request Insurance Second Opinion
Continuation of Medical Care Workers' Compensation Legal
Changing Physicians School Other:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I realize that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

By signing below, I acknowledge that I have read and understand this Authorization for Use or Disclosure of Protected Health Information.

Signature of Patient or Authorized Person Relationship Date

Witness
OFFICE USE ONLY Processed By:
HIM LAB X-RAY NURSING DHS
SIGNATURE: Date:

OFFICE USE ONLY
Reason for Unprocessed Release: Initial/Date:
Missing Patient Information
Missing Authorized Signature
Missing Where to Release / What to Release
Other: