General Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION:

I authorize the use or disclosure of my health information as follows:

Name of individual: _____ Date: _____

Address: _____

Telephone: _____ Medical Record #: _____ Date of Birth: _____

SJM Behavioral Services is authorized to make the requested *use or disclosure* of my Protected Health Information.
(Facility to release information)

The following person or class of persons is authorized to *receive* my Protected Health Information

Name and Address: **Axiom Requisition Copy Service, 447 North Canal Road, Lansing, MI 48917**

My health information will be used or disclosed for the following purpose(s) (ex: Marketing Activities, Fundraising Activities, employment determination, etc.) (To be completed by Requestor or Individual. Individual may write "At the request of the individual") _____

This Authorization applies to the following information:

☐ The following records or types of health information (specify date(s) of service): _____

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ X-Ray Report
- ☐ Laboratory and Pathology Report
- ☐ Emergency Room Report
- ☐ Cardiopulmonary/EKG Report
- ☐ Physical Therapy Notes
- ☐ Physician Progress Notes
- ☐ Nursing Notes
- ☐ Consultation Report
- ☐ Other (Please Specify) _____

☐ All billing information pertaining to the following date(s) of service _____

☐ All billing information pertaining to dates of service on or after _____

☐ Other (please specify): _____

EXPIRATION:

This authorization expires: **Twelve (12) months from the date of signature**

*The following information may be in the records that I have asked to be disclosed. Saint Joseph Mercy Health System may disclose these specific pieces of information if they are part of the requested records. (Please check the box next to any information that may be disclosed. If no box is checked, this specific information may not be disclosed.)

☐ Information about the diagnosis and testing for:

- ☐ HIV (Human Immunodeficiency Virus)
- ☐ AIDS (Acquired Immunodeficiency Syndrome)
- ☐ ARC (Aids Related Complex)

☑ Information about alcohol and drug treatment

☑ Information about mental health services and social services (including communications made by me to a social worker or mental health professional)

YOUR RIGHTS:

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this Authorization.

I understand that if the person or entity 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 no longer protected by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.

I understand that I may revoke this limited Authorization in writing at any time at the address found below, except to the extent that action has been taken in reliance on this Authorization. This Authorization is in effect until revoked by me or until it expires under applicable laws. An exception for registered chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.

☑ If this box is checked, the Requestor will receive payment for the use or disclosure of my information. I understand that the requestor will receive payment, either directly or indirectly as a result of uses and disclosures of my protected health information that I have authorized by signing this Authorization.

_____ _____

Signature of Patient or Representative Date

_____

Relationship to the patient (if Personal Representative)

_____ _____

Signature of Workforce Member (Witness) Date

This form should be mailed to:
Saint Joseph Mercy Behavioral Services – Outpatient
2006 Hogback Road, Suite 1, Ann Arbor, MI 48105

NOTICE OF FEDERAL AND STATE LAWS FURTHER DISCLOSURE TO THIS PERSON OR ORGANIZATION RECEIVING INFORMATION
"This information may have been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal regulations (42 CRF, Part 2) and State law (Public Act 258, Chapter 7, Section 748) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this pupose."

REVOCATION OF THIS AUTHORIZATION I hereby revoke the authorization made on _____.

_____ _____

Signature of Patient or Representative Date

_____

Relationship to the patient (if Personal Representative)

This revocation should be mailed or faxed to: Saint Joseph Mercy Behavioral Services – Outpatient
2006 Hogback Road, Suite 1, Ann Arbor, MI 48105 FAX (734) 712-4315