

Authorization for Schoolcraft Memorial Hospital To Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____ Med Rec No. _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record.
- Health care information in my medical record relating to the following treatment or condition:

Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____
- check only if (practice/facility requests the authorization for marketing purposes
- check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes
- This authorization ends:** (*This document does not permit disclosure of health information created more than 90 days after the date it is signed*)
- in 90 days from the date signed
- on (date): _____
- when the following event occurs: _____
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization I order to get health care benefits (treatment, payment or enrollment). However I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Schoolcraft Memorial Hospital based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
 - Fill out a revocation form. A form is available from the medical records department. Or
 - Write a letter to the medical records department of Schoolcraft Memorial Hospital.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of patient

Relationship
(parent, legal guardian, personal representative)