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 marking 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)