Sturgis Hospital

Quality Healthcare... Then, Now & Always

916 Myrtle Avenue • Sturgis, MI 49091-2391

MR# ______________
ACCOUNT # ______________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________
Phone Number: ______________________

I hereby Authorize Sturgis Hospital to use or disclose my protected health information indicated below to:

____
Name of Person and/or Agency

____
Street Address

____
City, State & Zip Code
Phone number: *Fax number:*

Specific Type of Information and Date(s) of Treatment to be Disclosed: please check all boxes that apply

☐ Discharge Summary ______________ ☐ ER reports ______________
☐ History and Physical Exam ______________ ☐ LAB reports ______________
☐ Operative reports ______________ ☐ Radiology reports ______________
☐ Consult reports ______________ ☐ Other: ______________

Purpose and Need for Such Disclosure

☐ Personal Use ☐ Continuing Care ☐ Insurance ☐ Attorney/Legal ☐ Other

☐ I wish my request to be FAXED. ☐ I **do not** wish my request to be FAXED.

I hereby consent to the release and/or review of any medical information which may include the following: records of alcohol, drug abuse, psychiatric illness, and any other information regarding communicable disease and serious communicable diseases which includes venereal diseases, Tuberculosis, Hepatitis B, HIV infection, Acquired Immunodeficiency Syndrome (AIDS), or Acquired Immunodeficiency Syndrome Complex (ARC).

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I understand that this authorization may be revoked by me at any time by notifying Health Information Management, in writing, of my desire. I understand that revocation of this authorization will not affect any information already released. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization shall expire without express revocation 90 days (3 months) from the date written below OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

____

I have read the above and fully understand its contents in its entirety.

______________________ ______________________ ______________
Signature of patient or authorized representative *Description of Authority to Act for the Individual* *Date*

For Facility Use:
Date Received: ______________ Date Information Released: ______________
Prepared by: