

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below:

Patient's Name: _____

<p>(please print clearly) Previous Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p>	<p>Date of Birth: _____</p> <p>Day Phone: () _____</p> <p>Evening Phone: () _____</p>
<p>Authorized to: (please circle your choice) RELEASE or RECEIVE the Personal Health Information</p> <p>Please check all that apply:</p> <p>☐ Helen Newberry Joy Hospital</p> <p>☐ Gibson Family Health Center (all providers)</p> <p>☐ Dr. Beaulieu</p> <p>☐ Dr. Gill</p> <p>☐ Dr. Rao ☐ Other: _____</p> <p>☐ Dr. Webb</p> <p>☐ Manistique Lakes Family Clinic</p> <p>☐ West Mackinac Health Clinic</p> <p>☐ Gibson 2nd Floor _____</p> <p>☐ Surgical Suite _____</p>	<p>Authorized to: (please circle your choice) RELEASE or RECEIVE the Personal Health Information</p> <p>Name <u>Legal-Ease Digital Imaging LLC</u></p> <p>Address <u>2496 Meadowcroft Dr</u></p> <p>City <u>Burton,</u> State <u>MI</u> Zip <u>48519</u></p> <p>Phone # <u>855-543-4003</u> Fax # <u>810-547-4030</u></p>
<p>502 W. Harrie Street Newberry, MI 49868</p> <p>Health Information Phone # (906) 293-9236</p> <p>Health Information Fax # (906) 293-3753</p>	<p>I authorize the disclosure of my healthcare record as described below, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency or abuse, psychological or social service records, or any such related information.</p>
<p>Information to be released (please check all that apply)</p> <p>Hospital Records:</p> <p>Dates of Service/Range:</p> <p>☐ _____ ED</p> <p>☐ _____ Lab(s) Report</p> <p>☐ _____ X-ray(s) Report</p> <p>☐ _____ EKG / Stress Test / Echo / Holter / Sleep Study / PFT</p> <p>☐ _____ Operative / Procedure Report</p> <p>☐ _____ Inpatient Record</p> <p>☐ _____ H&P / Progress Note(s) / Discharge Summary</p> <p>☐ _____ Nursing Records</p> <p>☐ _____ Other: _____</p>	<p>Information to be released (please check all that apply)</p> <p>Clinic or Physician Office Records:</p> <p>Dates of Service/Range:</p> <p>☐ _____ Office Note / T-Sheet /Progress Note</p> <p>☐ _____ Discharge Instructions</p> <p>☐ _____ Physical</p> <p>☐ _____ Medication List / Problem List / Medical Summary</p> <p>☐ _____ Immunization Record</p> <p>☐ _____ Lab(s) Report</p> <p>☐ _____ X-ray(s) Report</p> <p>☐ _____ Referral Reports / Consultations</p> <p>☐ _____ Other: _____</p>

Purpose of the disclosure (please check one): ☐ Continuing Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other: _____

Important Information About Your Privacy Rights I have read and understood the following statements about my privacy rights:

- ☐ I may revoke this authorization at any time prior to its expiration date by notifying the Health Information Management Director in writing, the revocation will not have any effect on any actions taken prior to the revocation.
- ☐ I may request a copy of this signed authorization from the Health Information Management Department.
- ☐ I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- ☐ I understand there may be a fee to process this release of information.
- ☐ Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
- ☐ This authorization will expire in 6 months from the date of execution or upon the following date or event: _____

Signature of Patient or Patient's Legal Representative*

Date

Witness Signature

Date

*If authorization is being signed by a personal representative of the individual, documentation of their authority to act must be provided.