

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Section 1: Patient Information** (please print/type)

|                                  |                            |               |                          |
|----------------------------------|----------------------------|---------------|--------------------------|
| Last Name                        | First Name                 | Middle Name   | Date of Birth (MM/DD/YY) |
| Home Phone Number (###-###-####) | Cell Number (###-###-####) | Email address |                          |
| Street Address                   | City                       | State         | Zip                      |

**Section 2:** I authorize Munson Healthcare facilities, clinics and providers (to include Cancer, Primary Care, etc.) to: Release information contained in my patient medical record **TO** the individuals or organizations identified in section 6 for the purposes and conditions designated on this form.

**Specify which Munson Healthcare location where services were received:**

**Section 3:** I authorize Munson Healthcare to get health information **FROM** this provider or facility:

☐ **SKIP SECTION 3 and proceed to SECTION 4 if you are not requesting MHC to get information FROM a provider or facility.**

Name of provider/facility: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Name of provider/facility: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Address: \_\_\_\_\_

**Section 4: Specific Health Information to be released or disclosed:**

Provider reports & test results for dates of service from: \_\_\_\_\_ to \_\_\_\_\_  
 Complete copy of my medical record for dates of service from: \_\_\_\_\_ to \_\_\_\_\_ (charges may apply)  
 Other: (please describe) \_\_\_\_\_ Dates of services: \_\_\_\_\_  
 Other: (please describe) \_\_\_\_\_ Dates of services: \_\_\_\_\_

**NOTE:** For drug and alcohol use treatment records please use form 1178 Behavioral Health and SUD Authorization for Release of Information.

**Section 5: Format** ☐ Paper ☐ PDF ☐ on encrypted CD\* ☒ on encrypted USB\* (\*may not be available at all locations)  
☐ Other electronic: \_\_\_\_\_

**Section 6:** Select whom to send the protected health information and how to send it

☐ **MYSELF** ☐ USPS mail (to the address listed in section 1) ☐ Fax to: \_\_\_\_\_ (limited to 25 pages)  
☐ Encrypted Email (listed in section 1) \_\_\_\_\_ Area Code/Fax Number (###-###-####)

☒ **SEND TO**

|                                              |                                                    |
|----------------------------------------------|----------------------------------------------------|
| Other Individual/Person Name<br>Pat Clifford | Company/Organization<br>Legal-Ease Digital Imaging |
| Street Address<br>2496 Meadowcroft Dr        |                                                    |
| City<br>Burton                               | State<br>MI                                        |
| Zip<br>48519                                 | Phone Number (###-###-####)<br>855-543-4003        |

☒ **FAX TO** 810-547-4030 Attention: Pat Clifford  
 Area Code/Fax Number (###-###-####) \_\_\_\_\_ Name of Recipient \_\_\_\_\_

☒ **ENCRYPTED EMAIL TO** pat.legalease@gmail.com

☐ Other delivery method (specify): \_\_\_\_\_

Health Information sent in an unencrypted email or on unencrypted media (DVD/flash drive) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted email or on unencrypted media, you are acknowledging and accepting these risks.

**Section 7: Purpose of request/disclosure:**

☐ Personal use    ☐ Continuation/coordination of care

☒ Other: (please specify) Litigation

**Section 8: By signing this Authorization patient or representative understands and consents to the disclosure of the information as stated within this document and agrees to the following:**

- I will not hold Munson Healthcare or its associated clinics liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- Failure to provide all information requested on this release form may invalidate this Authorization.
- I may refuse to sign this Authorization and my health care cannot be conditioned upon signing this Authorization.
- My Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.
- I can revoke (cancel) this Authorization at any time, except in circumstances in which the facility has taken actions in response to this Authorization. I understand this revocation must be submitted in writing.
- The information that I am authorizing to be released may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex). It may also include information about behavioral or mental health services, and reference a referral or treatment for alcohol and drug abuse (as permitted by CFR Part 2).

This authorization will expire one year from the date of signing or otherwise by my choice, in which case this consent will expire on: \_\_\_\_\_  
Date

Patient/other legal guardian or personal representative signature \_\_\_\_\_

\_\_\_\_\_ Date

\_\_\_\_\_ Time

Relationship to patient ☐ if patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable

**PLEASE RETURN THIS DOCUMENT TO THE APPROPRIATE LOCATION BELOW BY MAIL, FAX, EMAIL OR IN PERSON**

**MH Cadillac Hospital**  
ATTN: HIM  
400 Hobart St.  
Cadillac, MI 49601  
Fax: 231-876-7339  
Email: CAD-ROI@mhc.net

**MH Charlevoix Hospital**  
ATTN: HIM  
14700 Lake Dr.  
Charlevoix, MI 49720  
Fax: 231-547-8891  
Email: CHX-ROI@mhc.net

**MH Manistee Hospital**  
ATTN: HIM  
1465 E. Parkdale Ave.  
Manistee, MI 49660  
Fax: 231-398-1091  
Email: MST-ROI@mhc.net

**MH Grayling Hospital and  
MH Paul Oliver Memorial Hospital**  
Fax: 312-836-7919  
Email: Munson@VRCNetwork.com

**Kalkaska Memorial Health Center**  
ATTN: HIM  
419 S. Coral St.  
Kalkaska, MI 49646  
Fax: 231-935-7895  
Email: KMH-ROI@mhc.net

**MH Otsego Memorial Hospital**  
ATTN: HIM  
825 N. Center Ave.  
Gaylord, MI 49735  
Fax: 989-731-6039  
Email: OMH-ROI@mhc.net

**Munson Medical Center**  
ATTN: HIM  
1105 6th St.  
Traverse City, MI 49684  
Fax: 231-392-7308  
Email: MMC-ROI@mhc.net

**For MH Physician office or other MH clinic records:**  
Submit this document directly to the office where care was received

**INTERNAL USE ONLY**

☐ Request completed by: \_\_\_\_\_  
Name Dept. Date

☐ Identification verified by driver's license/or other means: \_\_\_\_\_  
Name Dept. Date