



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

☐ Sheridan Community Hospital
301 N. Main St.
PO Box 279
Sheridan, MI 48884
Phone: 989-291-6341
Fax: 989-291-3775

☐ Sheridan Care
303 Congress St.
PO Box 230
Sheridan, MI 48884
Phone: 989-291-5077
Fax: 989-291-5348

Patient Name _____ SSN _____ DOB _____
You are not required to tell us the purpose of your request. If you do not wish to tell us, simply check the following box:
☐ At My Request If you wish to provide more detailed information, you may do so below:

I authorize _____ to release or disclose health information of the above named individual to:

Name: Legal-Ease Digital Imaging Pat Clifford
Address: 2496 Meadowcroft Dr
City / State / Zip Code: Burton, MI 48519
Phone: 855-543-4003 Fax: 810-547-4030

This authorization is made in accordance with federal and state laws. Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information below _____.

I understand that I may revoke this authorization at any time by sending a written revocation to Sheridan Community Hospital, except to the extent that it has taken action in reliance on the authorization.

I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-Disclosure or release by the Receiving Party and may no longer be protected by federal or state laws.

Date(s) of Visits: _____

- | | |
|--|--|
| ☐ Discharge Summary | ☐ Test Results (EKG, EEG) |
| ☐ History & Physical | ☐ Lab Reports |
| ☐ Progress Notes | ☐ X-rays & Ultrasounds |
| ☐ ER/OP Records | |
| ☐ Records related to specific problem of: _____ | |
| ☐ Other: _____ | |

Signature of Patient or Legal Representative

Authorization expires one year from date above

Description of Authority to Act for Patient - Relationship to Patient

Witness

Verification of: _____ Driver's License _____ POA _____ Guardianship _____ Court Appointment _____ Proof of Emancipation

This authorization form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations 45 CFR Parts 160 and 164. Previous edition obsolete. PVH/HIM