

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Phone Number: _____

The Patient hereby authorizes Straith Hospital for Special Surgery (the "Hospital") to release and disclose the following information in my medical records maintained by the Hospital:

- | | |
|--|--|
| ☐ Records covering the period from: _____ (date) to: _____ (date) | |
| ☐ Discharge Summary | ☐ Operative Reports |
| ☐ Labs | ☐ Complete Copy of Medical Record |
| ☐ Radiology/X-Ray, including MRI/CT | ☐ Progress Notes |
| ☐ Other: _____ | ☐ Medication List |

Recipient. I authorize the release and disclosure to the following individual or organization:

Name (or title) / Organization: Legal-Ease Digital Imaging

Address: 2496 Meadowcroft Dr Burton, MI 48519

Phone: 855-543-4003 Fax: 810-547-4030 E-Mail: pat.legalease@gmail.com

Format. The health information should be provided to Recipient in the following manner (please select one; if none selected, information will be provided in hard copy by Mail):

☐ Mailed ☒ Faxed ☐ Picked Up ☐ Electronic Portal ☐ Other (describe on a separate sheet)

Electronic Format Requested: _____

If Picked Up is selected, provide name of who will Pick Up if someone other than Patient: _____

Patient Rights. I understand that: (i) authorizing the disclosure of health information to Recipient is voluntary, (ii) this Authorization covers multiple requests for and disclosures of health information and authorizes the Hospital to make such disclosures, (iii) treatment may not be conditioned upon providing this Authorization (unless treatment is sought only to create health information for a third party or to take part in a research study), and that I may have the right to refuse to sign this Authorization, (iv) any disclosure of health information carries with it the potential for an unauthorized re-disclosure by the Recipient and the disclosed information may no longer be protected by federal or state privacy rules, (v) if a fee applies, I may be required to pre-pay for the copies or the copies will be mailed along with an invoice, and (vi) I will receive a copy of this Authorization after I have signed it, and a copy of this Authorization is as valid as the original.

Expiration Date. This Authorization expires three (3) years from the date signed. This Authorization may be revoked in writing, at any time, by providing a signed revocation to Hospital's HIPAA Privacy Official at the address listed above. Revocation will become effective on the date when the written revocation notice is received, but will have no impact on disclosures of health information that have already been made prior to the revocation date.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION PRIOR TO HOSPITAL'S DISCLOSURE OF HEALTH INFORMATION TO RECIPIENT, HOSPITAL IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF FAILURE TO DISCLOSE ANY INFORMATION TO THE RECIPIENT AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT HOSPITAL IS NOT RESPONSIBLE FOR HOW THE RECIPIENT USES OR FURTHER DISCLOSES PATIENT'S INFORMATION, AND I WILL NOT HOLD HOSPITAL AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF REVOCATON OF THIS AUTHORIZATION AND/OR ANY AUTHORIZED DISCLOSURE PURSUANT TO THIS AUTHORIZATION.

Patient Signature or, if Patient is unable to sign,
Signature of Patient Advocate / Representative *

Date

*If Patient is unable to sign, secure signature of
Patient Advocate, Representative, Next of Kin
and indicate reason why Patient is unable to sign: ___ Minor ___ Disoriented ___ Incompetent ___ Medically Unstable*

Name of Patient Advocate / Representative
and Relationship to Patient (Please print)

☐ Documents of Relationship to Patient Attached

(*) In the event of a deceased or incapacitated patient, the Authorized Representative must provide proof of status, i.e. death certificate or court order.

Additional Consent for Certain Conditions:

I also authorize the Hospital to disclose and release the following information to Recipient (unless the appropriate box is specifically checked, health information relating to the following topics will NOT be disclosed):

- ☐ Alcohol or other substance use disorder, dependency or abuse (Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records)
- ☐ Communicable diseases and infections as defined by statute and Michigan Department of Public Health rules (which include "VD", "TB", "HIV", "AIDS and AIDS related complex "ARC").
- ☐ Mental health treatment records, psychological services and social services information communications made by me to a social worker or psychologist
- ☐ Physical or sexual abuse
- ☐ Abortion
- ☐ Michigan Automated Prescription System Information

Patient Signature or, if Patient is unable to sign,
Signature of Patient Advocate / Representative

Date