

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:

Pat Clifford / Legal-Ease Digital Imaging LLC

Name of Person and/or Agency

2496 Meadowcroft Dr

Street Address

Burton, MI 48519

City, State & Zip Code

Phone number: 855-543-4003

Fax number: 810-547-4030

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: _____

