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HIMCoordinators@UMHSparrow.org

Authorization for Disclosure of Protected Health Information

Patient's Full Name: _____

Birth Date: _____

Address: _____

Telephone Number: _____

City/State/Zip: _____

1. I hereby authorize UM Health-Sparrow (_____) to disclose my protected health information including copies of my medical record to the person or organization to receive information below.

I acknowledge, and hereby consent to such, that the released information may contain the following:

Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.

Information about communicable diseases, human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC as defined by Department of Community Health rules (1989 Public Act 174).

Receiving party or agency (insert name, address, email address (if known) and telephone/fax number)

Legal-Ease Digital Imaging LLC 2496 Meadowcroft Dr Burton, MI 48519 PH: 855-543-4003 FX: 810-547-4030

2. **Date(s) of Service:** _____

Location: **Hospital:** ☐ Sparrow Main ☐ Clinton ☐ Ionia ☐ Carson City ☐ Eaton ☐ Sparrow Specialty

Other Sparrow Facility: ☐ Sparrow Urgent Care ☐ Sparrow Fast Care ☐ Sparrow Medical Group

Address/Location: _____

☐ Thoracic Cardiovascular Institute ☐ Behavioral Health ☐ Herman-Herbert Cancer Center
☐ Sparrow Laboratories ☐ Sparrow Physician: _____

3. **Specific type of information to be used or disclosed:**

☐ Discharge Summary ☐ Laboratory Reports ☐ Emergency Room Records ☐ History and Physical
☐ Imaging Report ☐ ECHO/EKG ☐ Consultation Reports ☐ Operative Report
☐ Pathology Report ☐ Pulmonary Function ☐ Autopsy Report
☐ Other: _____
☐ Entire Record (includes all the above except the imaging cd/films, cardiac catheterization imaging and billing records)
☐ Imaging CD/Films ☐ Cardiac Cath Imaging ☐ Billing

4. The above information may be used and disclosed for the following reasons.

☐ Personal ☐ Insurance ☐ Medical Care ☒ Legal Matters (Attorney) ☐ Other _____

5. Indicate the format in which you would like to receive your requested information to be sent.

☐ MySparrow Patient Portal ☒ Electronic Copy (CD) ☐ Paper Copy ☐ Mail
☒ USB Flash Drive ☒ Email pat.legalease@gmail.com
☒ Fax to 810-547-4030

6. I understand that:

- I may revoke my authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to my receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or a health care provider, the release of information may no longer be protected by federal privacy regulations and may be re-disclosed.
- This authorization automatically expires once the purpose for which it was signed is accomplished and/or 12 months from the date of signature

Patient/Authorized Representative Signature

Print Name

Date