MUNSON HEALTHCARE

PATIENT / CLIENT NAME	DATE OF BIRTH

ADDRESS (street, city, state, zip)

I hereby authorize KALKASKA MEMORIAL HEALTH CENTER
(HOSPITAL / PROVIDER / PROGRAM NAME & ADDRESS)
its Director of designee, or Medical Record Department, to release information contained in my patient records to the individuals or organizations listed below, only under the circumstances listed below:

Information to be released to: RECORDS DEPOSTION SERVICE, INC.
(NAME OF PERSON(S) TO WHOM DISCLOSURE IS TO BE MADE)

Attention: PHONE: (248)-357-3330; FAX: (248)-357-3337
(NAME OF PERSON(S) TO WHOM DISCLOSURE IS TO BE MADE)

PO BOX 5054, SOUTHFIELD, MI, 48086-5054
ADDRESS CITY STATE ZIP

Relationship of this person / organization to me (example: Primary Care Provided) _____

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC).

DATES OF HOSPITALIZATIONS OR OUTPATIENT SERVICES:

_____ _____ _____ _____ _____ _____ _____

☐ History & Physical Examination
☐ Assessment
☐ Communication Exchange
☐ Psychosocial
☐ Behaviorial Notes
☐ Operative/Procedure Report
☐ Progress Reports
☐ Discharge Summary
☐ Diagnostic Test Results
☐ Treatment Plan
☐ Billing Information
☐ Entire Chart
☐ Pertinent Information
(Pertinent information includes: Any and all dictated reports and any and all test results)
☑ Other
(Specify information e.g. films, slides, etc.)
SEE ATTACHED SUBPOENA FOR RECORDS WANTED

☐ Continuation of Care
☐ Vocational Rehabilitation
☐ Insurance/Billing Verification
☐ School
☐ Disability Determination
☐ Social Service Referral
☐ Legal Follow-Up
☐ Care Conference
☐ Referral Follow-Up
☐ Return to Work
☐ Personal Use
☑ Other:
PRE-TRIAL DISCOVERY

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret.

I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I will not hold Munson Healthcare 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.

I understand that failure to provide all information requested may invalidate this authorization.

I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

This authorization is subject to a written revocation at any time except in those circumstances in which the Hospital has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire one year from the date of signing, if not otherwise designated ("none" may be specified).

REVOCATION (optional) - This authorization is revoked for the following specified dates, events, or conditions.

Date: _____ Event: _____ Condition: _____

This authorization must be dated subsequent to the hospitalization that you are requesting except in cases of ongoing treatments.

SIGNATURE	TIME / DATE	WITNESS	TIME / DATE
RELATIONSHIP TO PATIENT	☐ If patient is a minor or incapable of signing, a copy of the appropriate legal documentation is attached, if applicable.		

☐ DRIVER'S LICENSE / IDENTIFICATION VERIFIED, AS APPLICABLE.