SAINT JOSEPH MERCY HEALTH SYSTEM

General Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with applicable State and Federal law. Failure to provide all information requested may invalidate this Authorization.

Date of Request: _____ Medical Record Number (if known) _____

1. Protected health information may be used or disclosed regarding the following person:

   Name: (Last)_____(First)_____(M.I.)_____ Date Of Birth _____

   Address: (Street/box) _____(City)_____(State)_____(Zip)_____

   Telephone: (day) (____) _____ (eve) (____) _____ Social Security #: _____ (Optional)

2. The following person or facility is authorized to disclose my Protected Health Information

   Name of Person or Facility _____ (Phone) (____) _____

   Address: (Street/box) _____(City)_____(State)_____(Zip)_____

3. The following person or facility is authorized to receive my Protected Health Information

   Name of Person or Facility: RECORDS DEPOSITION SERVICE, INC. (Phone) (248) 357-3330

   Address: (Street/box) BO POX 5054 (City) SOUTHFIELD (State) MI (Zip) 48086-5054

4. My health information will be used or disclosed for the following purpose(s) (ex: Marketing Activities, Fundraising Activities, Employment Determination, Continued Care, Legal, Claims etc.): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

5. This Authorization applies to the following information*:

   ☐ The following records or types of health information (specify date(s) of service): _____

   ☐ Discharge Summary
   ☐ X-ray Report
   ☐ Physical Therapy Notes
   ☐ Physician Progress Notes
   ☐ Emergency Room Report
   ☐ History and Physical
   ☐ X-ray Film (avail from Radiology Dept)
   ☐ Cardiopulmonary/EKG Report
   ☐ Nursing Notes
   ☐ Operative Report
   ☐ Laboratory and Pathology Report
   ☐ Other (Please Specify)_____
   ☐ Consultation Report
   ☐ Multidisciplinary Notes
   ☐ Billing Information (available from Patient Financial Services)

6. Patient Only
   ☐ Paper
   ☐ Electronic

* Information about the diagnosis and testing for HIV, AIDS, and ARC; Information about alcohol and drug treatment; and Information about mental health services and social services (including communications made to a social worker or mental health professional) may be contained in these documents and will be disclosed if it is part of the requested records. If you do not wish to have this information disclosed, please initial here:_____ .

7. This Authorization expires:_____ (if no expiration date or event is listed, this authorization will expire 90 days after the date of request or at the completion of the request, whichever is earlier)
   ☐ If this box is checked, I understand that the person or facility requesting my authorization will receive direct or indirect payment for the uses and disclosures I have authorized.

_____ _____ _____
Signature of Patient or Personal Representative Date Time

_____
Relationship to the patient (if Personal Representative)

For Office Use Only: Identity and Authority Validated: _____ (initials) Date Request Received _____

Notice Of Federal And State Laws Regarding Further Disclosure To The Person Or Organization Receiving Information"This information may have been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal regulations (42 CFR, part 2) and State law (Public Act 258, Chapter 7, section 748) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

Please see Pg. 2 for information on your rights and for mailing information

YOUR RIGHTS:

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.

I understand that I may revoke this limited authorization in writing at any time at the address found below, except to the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires under applicable laws. An exception for registered chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.

This form should be mailed to:

☐ St. Joseph Mercy Ann Arbor
Health Information Management
5301 East Huron River Drive
P.O. Box 995
Ann Arbor, MI, 48106-0995

☐ St. Joseph Mercy Livingston
Health Information Management
620 Byron Road
Howell, MI 48843

☐ Other _____

_____

_____

_____

_____

REVOCATION OF THIS AUTHORIZATION

I hereby revoke the authorization made on _____.

_____ _____ _____

Signature of Patient or Representative | Date | Time

_____

Relationship to the patient (if Personal Representative)

This revocation should be mailed to:
St. Joseph Mercy Ann Arbor
Health Information Management
5301 East Huron River Drive
P.O. Box 995
Ann Arbor, MI, 48106-0995