Hillman Clinic
PO Box 427
Hillman, MI 49746
(989) 742-4583
(989) 742-2183 fax

Atlanta Clinic
PO Box 850
Atlanta, MI 49709
(989) 785-4855
(989) 785-2267 fax

Rogers City Clinic
205 S. Bradley Hwy
Rogers City, MI 49779
(989) 734-2052
(989) 734-7390 fax

Onaway Clinic
PO Box 722
Onaway, MI 49765
(989) 733-2082
(989) 733-8487

Onaway School Based Health Center
4549 M-33
Onaway, MI 49765
(989) 733-4980
(989) 733-7064 fax

THUNDER BAY COMMUNITY HEALTH SERVICE, INC.
RELEASE OF INFORMATION
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, ____/____/____, hereby authorize
(Patient Name) *(Date of Birth)*

Thunder Bay Community Health Service, Inc. to [X] **release** my medical or dental records to:
- *OR* -[ ] **obtain** my medical or dental records from:

Name: Records Deposition Service, Inc. Phone: 248-357-3330

Address: P.O. Box 5054 Fax: 248-357-3337

City: Southfield State: MI Zip Code: 48086-5054

Type of information to be disclosed or obtained: (check all that applies):

[ ] Problem List [ ] Allergy List [ ] Consultation Report [ ] X-Ray Reports [ ] Progress Notes
[ ] Medication List [ ] Lab Tests [ ] *Behavioral Health* [ ] Entire record
[ ] Immunizations [ ] Dental Records *Approval:* _____ [X] Other: Please see enclosed Letter Request
Date: _____ [ ] Discussion for information to be disclosed.

Covering healthcare from/to (date): _____ to (date): _____

I understand, indicated by my initials, this authorization may include information relating to:

_____ Communicable and/or infectious diseases, include Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), tuberculosis, or sexually transmitted diseases.

_____ Substance, alcohol and/or drug, abuse.

_____ Behavioral or mental health services, or psychological and social services including child abuse, developmental disabilities, or mental illness.

Purpose of Disclosure:
This information for which I am authorizing disclosure will be used for the following purpose:
[ ] My personal records [ ] Sharing with other health care providers as needed
[X] Other (please describe) For discovery before trial.

Re-Disclosure of Health Information:
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Patient Rights:
I understand that.....
• I can see and copy the health information described above and that I will receive a copy of this authorization form after I sign it.
• I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Patient Name: _____ Date of Birth_____

Expiration of Authorization:
I understand that my authorization will expire in 60 days or ☐ 6 months, unless otherwise revoked.

I understand I can revoke this authorization in writing at the above named clinic sites at any time, except to the extent that my information has already been disclosed in good faith based on this authorization.

I have reviewed and understand this Authorization to Disclose Protected Health Information and agree it accurately reflects my wishes.

Patient Signature: _____ **Date:** _____

Patient's Legal Representative: _____ **Date:** _____

Representative Relationship to Patient: _____

Witness Signature: _____ **Date:** _____