

MERCY – PORT HURON
2601 Electric Avenue, Port Huron, MI 48060-6518

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize release of health information for the individual named below.

Patient Name	Date of Birth	Social Security Number																																																
Address (Street, City, State, Zip Code)		Telephone Number																																																
I authorize Mercy - Port Huron to release information to:																																																		
(or) I authorize the organization named below to release information to Mercy – Port Huron:																																																		
Treatment dates:	Purpose of Request:																																																	
The following information is to be disclosed: (please check) <table style="width: 100%; border: none;"> <tr> <td style="width: 5%;">Yes</td> <td style="width: 5%;">No</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Discharge Summary</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....History & Physical Examination</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Consultations (including psychiatric evaluations)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Operative Report or Procedure Reports</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Laboratory Reports (including drug screens)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Radiology or Imaging Reports</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Emergency Department Record</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Cardiac Studies</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Progress Notes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Medication Administration Records (MARs)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Nursing Notes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Physician Orders</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Complete Medical Record</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Billing Record (itemized statement)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>.....Other _____</td> </tr> </table>		Yes	No		<input type="checkbox"/>	<input type="checkbox"/>Discharge Summary	<input type="checkbox"/>	<input type="checkbox"/>History & Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>Consultations (including psychiatric evaluations)	<input type="checkbox"/>	<input type="checkbox"/>Operative Report or Procedure Reports	<input type="checkbox"/>	<input type="checkbox"/>Laboratory Reports (including drug screens)	<input type="checkbox"/>	<input type="checkbox"/>Radiology or Imaging Reports	<input type="checkbox"/>	<input type="checkbox"/>Emergency Department Record	<input type="checkbox"/>	<input type="checkbox"/>Cardiac Studies	<input type="checkbox"/>	<input type="checkbox"/>Progress Notes	<input type="checkbox"/>	<input type="checkbox"/>Medication Administration Records (MARs)	<input type="checkbox"/>	<input type="checkbox"/>Nursing Notes	<input type="checkbox"/>	<input type="checkbox"/>Physician Orders	<input type="checkbox"/>	<input type="checkbox"/>Complete Medical Record	<input type="checkbox"/>	<input type="checkbox"/>Billing Record (itemized statement)	<input type="checkbox"/>	<input type="checkbox"/>Other _____	Method of Disclosure (please check one): <input type="checkbox"/> Mail to: <input type="checkbox"/> Fax to (Medical Facilities Only): Fax #: _____ <input type="checkbox"/> Call when ready for pick-up: Name: _____ Telephone #: _____
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Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.																																																		
Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, 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, as noted below.																																																		
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____																																																		
If I do not specify an expiration date, event or condition, this authorization will expire in six months.																																																		
Redisclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be redisclosed and no longer protected by these regulations.																																																		
Other Rights: I understand I may refuse to sign this authorization and that my refusal will not affect the use or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.																																																		
I may inspect or copy any information used/disclosed under this authorization.																																																		
Signature of Patient or Legal Representative		Date																																																
If Signed by Legal Representative, Relationship to Patient																																																		