



PATIENT ACCESS AND AUTHORIZATION FORM

Patient Last Name:	First Name: M.I.
Date of Birth:	Social Security Number:

I hereby authorize the use or disclosure of personal health information about me as described below:

- | | | |
|-----------------------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Billing Statement |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health/Psychotherapy Notes |
| <input type="checkbox"/> Other components (specify) _____ | | |

1. The following person(s) or group of persons employed or working for Select Medical Corporation may disclose my protected health information, which is described above:

- | | |
|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Medical Records Staff | <input type="checkbox"/> Clinicians |
| <input type="checkbox"/> Admissions Staff | <input type="checkbox"/> Other (please specify) _____ |

2. Select Medical Corporation may release my protected health information, which is described above to the following person(s) or group of persons:

- | | | |
|------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Myself | <input checked="" type="checkbox"/> Attorney | <input type="checkbox"/> Life Insurance Agent |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Physician / Practitioner | <input type="checkbox"/> Research name of study: _____ |

NAME: MINUTE MAN SERVICES, INC.
ADDRESS: 3318 N. MAIN
ADDRESS:
CITY, STATE, ZIP: ROYAL OAK, MI 48073

3. If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- | | | |
|----------------------------------------------------|-----------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Surrogate Decision-Maker |
| <input type="checkbox"/> Executor of Personal Rep. | <input type="checkbox"/> Parent | <input type="checkbox"/> Other (please specify) _____ |

4. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Select Medical Corporation in reliance on this authorization, by sending a written revocation to: Select Medical Corporation, Attn: Privacy Officer, 4716 Old Gettysburg Road, Mechanicsburg, PA 17055.
6. I understand that I am not required to sign this authorization form and that Select Medical Corporation will not withhold the provision of treatment or payment to me as a condition of the signing of this authorization. I understand that Select Medical may condition the provision of healthcare to me that is solely for the purpose of created protected health information for disclosure to a third party on the signing of this authorization.
7. I authorize my health information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency virus "HIV", Acquired Immunodeficiency syndrome "AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2, psychological services and social services information including communications made by me to a social worker or psychologist, to be released to the individual(s) listed above.
8. This authorization will expire 12 months from the date of signature unless a shorter duration has been specified by the patient: _____

Signature of patient (or patient's representative)

Date

Name of personal representative, if applicable

Date

Signature of Select Medical Corporation representative

Date