AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (INSPECTION AND/OR COPY)

PATIENT NAME: ______________________________

Medical Record #:______________________ **Acct #**:______________________

Date of Birth: ______________________ **Date of Service**: ______________________

1. The following individual(s) or organization(s) are authorized to make the use or disclosure:
   ____
2. The information to be used or disclosed is as follows: (include specific meaningful description)
   ____
   ____
   ____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) and AIDS Related Complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, or serious communicable diseases as defined by the Department of Public Health Rules including Hepatitis B, Venereal Disease and Tuberculosis.
4. The information identified above may be used by or disclosed to the following individual(s) or organization(s):
   Name: ______________________________
   Address: ______________________________
   ____
5. This information for which I am authorizing disclosure will be used for the following purposes:
   ____
   ____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Director of Health Information Management. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. This authorization will expire ______________________. If I fail to specify an expiration date or event, this authorization will expire one year from the date of which it was signed.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations, although, such use/disclosure may be subject to other Michigan and federal laws.
9. I need not sign this form as a condition of receiving healthcare treatment.
10. This authorization follows Memorial Healthcare's Authorization Policy and Procedure.

______________________________ ______________________
Signature of patient or legal representative Date

______________________________ ______________________
Signature/Relationship of other Authorized Person Date

______________________________ ______________________
Signature of witness Date

I hereby acknowledge receipt of this authorization. ______________________________

Memorial Healthcare/ 826 W. King St. / Owosso, MI 48867

Distribution of copies: Original to Memorial Healthcare and copy to patient and/ or authorized person.