



805 S. Oakland
St. Johns. MI 48879

Authorization for Disclosure of Protected Health Information

Patient's Name: _____

Birth date: _____

Address: _____

Phone No.: _____

Social Security Number: _____

1. I authorize and request Clinton Memorial Hospital (or _____) to use or make a disclosure of my protected health information, including as applicable:

Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.

Information about human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information:

_____ Receiving party or agency (insert name and address)

_____ Sparrow Marketing Department

_____ Sparrow Foundation

3. Specific Type of information to be used or disclosed:

Dates of service: _____

_____ Problem list

_____ Medication list

_____ List of allergies

_____ Immunization record

_____ Most recent history and physical

_____ Most recent discharge summary

_____ Laboratory results from (date) _____ to (date) _____

_____ X-ray & imaging reports from (date) _____ to (date) _____

_____ Consultation reports from (doctors' names) _____

_____ Entire record

_____ Other _____

4. This information may be used and disclosed for the following purposes:

_____ Patient use

_____ Attorney use

_____ Marketing use

_____ Fundraising use

_____ Other use _____

5. This authorization permits the use and disclosure of health care information for marketing purposes as described above. NO YES

If the answer above is YES, Clinton WILL / WILL NOT receive remuneration from a third party for the use of this protected health information.

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- 6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.
- 7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.
- 8. I understand that I may revoke this authorization at any time by notifying Clinton Memorial Hospital (or _____) in writing by sending a letter to the attention of _____. However, the revocation will not be valid if Clinton Memorial Hospital (or _____) has taken action in reliance on this authorization.
- 9. This authorization expires on (date or event) _____ or 180 days from date of the signature below.

Printed name of patient or patient's representative

Signature of patient or patient's representative

Date

- 10. Complete only if patient or representative signs by use of a mark:

Printed name of witness

Signature of witness

Date

Printed name of witness

Signature of witness

Date

[If the above signature is that of a patient's representative, Clinton must complete the following.]

- 11. Clinton has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

Associate name and signature

Date