SCHOOLCRAFT MEMORIAL HOSPITAL
7870W US Highway 2 Manistique MI 49854
Hospital (906) 341-3200 Fax (906) 341-3281
RHC Phone (906)341-2153 Fax (906)341-3299

Medical Record Release of Information

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ City: _____ State/Zip code: _____

I authorize: _____
(Name)

_____
(address)

_____
(City/State/Zip)

_____
(Phone Number)

_____
(Fax Number)

Release to: SMH Rural Health Clinic

Dr., PA, NP: _____

7870W US Highway 2 Manistique, MI 49854

Phone: (906) 341-2153

Fax: (906) 341-3299 or (906) 341-1865

_____ Consent to release **ENTIRE MEDICAL RECORD** Date(s) of Service (DOS): _____

Specific Type of information to be disclosed:

____ History and Physical ____ Operative Report ____ Physician's Notes ____ Consultation Reports
____ Therapy Notes ____ Discharge Summary ____ Laboratory Results ____ Home Care Records
____ Diagnostic Imaging (E.G., X-Ray) Reports from (date) _____
____ Diagnostic Imaging (E.G., X-Ray) Reports from (date) _____

____ Other _____

Sensitive Information to be Disclosed: Date(s) Of Service: _____

_____ Behavioral and Mental Health Service Information (including Psychotherapy Notes) _____ Initial
_____ Referrals and Treatment for alcohol and substance use disorder _____ Initial
_____Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus _____ Initial
(HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

The Purpose of this disclosure of information is: _____

BY SIGNING THIS FORM, I UNDERSTAND:

1. This authorization will automatically expire on: _____ /_____ /_____ or one year from date of signature.
2. That I need not sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.
3. The sharing of my health information will follow state and federal laws and regulations.
4. This form does not give my consent to share psychotherapy notes as defined by federal law.
5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. I should tell all agencies and people listed on this form when I withdraw my consent.
7. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
8. That any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Patient's Legal Representative's Signature Date:

_____ Staff Initials: _____
Relationship if other than Patient: