SCHOOLCRAFT MEMORIAL HOSPITAL

MEDICAL RECORD RELEASE OF INFORMATION

Patient Name | **Date of Birth (MM/DD/YYYY)** | **Phone Number**

Address | **City, State** | **Zip Code**

I Authorize: (Please Check One or Both)

Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Fax: _____

Release to:

□ Schoolcraft Memorial Hospital (SMH) Fax: 906-341-3281
□ Rural Health Clinic (RHC) Fax: 906-341-3299
7870W US Highway 2
Manistique, MI 49854
Phone: 906-341-3200

Consent to Release **MEDICAL RECORD**

Date(s) of Service (DOS):_____

Specific Type of Information to be disclosed: (Check All That Apply)

____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)_____
____Entire Medical Record ____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

Purpose (Check all that apply): □ Patient Request □ Continuing Care □ Legal Investigation/Action
□ Insurance Eligibility/Benefits □ Other: _____

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 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 understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
6. Once Part 2 information has been initially disclosed (with or without patient consent), no redisclosure of information is permitted without the patient's express consent to redisclose or unless otherwise permitted under Part 2.
7. 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 been already 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.
8. I should tell all agencies and people listed on this form when I withdraw my consent.
9. 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)

_____

Patient or Patient's Legal Representative's Signature | Date

_____

Relationship, if other than Patient | Staff Initials