

MEDICAL RECORD RELEASE OF INFORMATION

Patient Name	Date of Birth (MM/DD/YYYY)	Phone Number
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Address	City, State	Zip Code
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I Authorize: (Please Check One or Both)

☐ 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

Release to:

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

Consent to Release **MEDICAL RECORD**

Date(s) of Service (DOS): _____

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

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Physician's Notes	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Therapy Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Home Care Records
<input type="checkbox"/> Diagnostic Imaging (E.G., X-Ray) Reports from (Date) _____			
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Other _____		

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

<input type="checkbox"/> Behavioral and Mental Health Service Information (including Psychotherapy Notes)	_____ Initial
<input type="checkbox"/> Referrals and Treatment for alcohol and substance use disorder	_____ Initial
<input type="checkbox"/> 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