HEALTHSOURCE Saginaw *Leading the way to recovery* **Release of Information Dept.** 3340 Hospital Road Saginaw, MI 48603-9622 Phone: (989) 790-7821 Fax: (989) 790-7880 HIM@hss-mi.org	**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**	For Office Use Only

INSTRUCTIONS:
Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

Patient Full Name	Maiden name/previous name		
Address	City	State	Zip code
Date of birth	Phone number		

☐ **Information may be shared verbally to help treat, manage and diagnose**

I hereby authorize my records be sent from:

☐ **HealthSource Saginaw**

☐ **Other Facility**

Other Facility Name/Organization			
Address	City	State	Zip Code
Phone number	Fax number		

It's director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. However, such notes may contain information on general medical care; psychological/mental and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers. Any alcohol and substance abuse information disclosed to you from records are protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

Information packets for: (will send required documentation)

□ Continued Care □ Educational □ Disability/SSD/SSI □ Dates of stay letter

OR

Information to be sent or shared:

□ Discharge Summary □ Initial Evaluation □ Physician Progress Notes □ PT/OT/ST notes
□ Psychosocial □ Labs/X-rays □ History & Physical □ Entire Record
□ Other _____

☐ **Please check box to include (if any) medical records for psychotherapy notes.**

1. Name or title of person or organization and address to whom information is to be disclosed to:

Name/organization			
Address	City	State	Zip code
Phone number	Fax number or email address		

- ☐ Paper Copy
- ☐ Faxed to the fax number above (limited by number of pages)
- ☐ Encrypted (secure) email to the email address provided above
- ☐ Unencrypted email to the email address provided above
- ☐ Electronically placed on a Flash Drive (this must be mailed to you)

IMPORTANT!
Health Information sent in an unencrypted email or on unencrypted media (flash drive) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information unencrypted email or on unencrypted media, you are acknowledging and accepting these risks. Your Social Security Number, home address, insurance information, medical information, and other personal information may appear on the records we are sending to you.

2. This authorization expires on _____ (specify expiration date or event). If date is left blank, authorization expires 60 days from the signature date.

3. I may revoke this authorization at any time by contacting HealthSource Saginaw – Health Information Management 3340 Hospital Rd., Saginaw, MI 48603-9622. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

4. My care or treatment will not be conditioned on signing this authorization.

5. HealthSource Saginaw reserves the right to charge for processing and copying information. Fees for copies are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL333.26269. This fee is waived when releasing information **directly** to a treating physician or health care facility.

NOTE: Once information has been disclosed, HSS can no longer protect it from further disclosure.

_____ _____ _____ _____

Signature of Patient or Legally Authorized Representative
(if patient is a minor or unable to sign)

Date (mm/dd/yyyy)

Witness

Date

_____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship to Patient: □ Spouse □ Parent □ Next-of-Kin □ Legal Guardian □ POA □ Heir-at-law

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON
If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. Please contact the Release of Information Dept. at (989) 790-7821 to determine the documentation that will be required to process this request.