Clinton County Medical Center
Patient's Authorization for Release of Protected Health Information

This form for Authorization for Release of Protected Health Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or state laws respecting confidentiality of records and patient communications with mental health professionals, other healthcare providers and medical center support staff.

Patient's Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Telephone _____ Date of Birth _____

The undersigned hereby authorizes:

_____,
Name and address of person(s) or organization(s) from which information is being requested

to release any and all information contained in the records of the patient listed above. INCLUDING INFORMATION REGARDING DRUG AND/OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST, OR PSYCHIATRIST, AND HIV/AIDS-RELATED COMPLEX DOCUMENTATION, to the individual(s) or organization(s) listed below.

Name of person(s) or organization(s) to whom disclosure is to be made:

Clinton County Medical Center
1005 S. US 27
St. Johns, MI 48879
Phone: 989-224-3000 Fax: 989-224-1424

Description of the specific information (include date(s) of service) to be used or disclosed _____

_____

This information is being requested for the following purpose(s):

[] At the request of the individual

[] Other, describe: _____

_____

This authorization is subject to revocation at any time, except to the extent that it has already taken action in reliance upon it. I may revoke this authorization in writing by contacting Medical Records (information from medical record) or Patient Accounts (information from billing record) at the address below. Unless earlier revoked, consent will expire 60 days from date signed.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

I understand that I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I understand that Michigan law allows CCMC to charge a reasonable fee for the requested copies from the medical record.

[] If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

_____ _____
Signature of PATIENT or PATIENT'S LEGAL REPRESENTATIVE Date

If signed by a legal representative, indicate his/her relationship to the patient (parent, guardian, etc.) and attach legal documentation:

_____ _____
Witness to Signature Date