



AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Job #: _____

MR #: _____

ID Checked: Initials: _____

Information About the Use or Disclosure

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below:

Individual's Name: _____
(Print or type full name)

Previous Name: _____

Date of Birth: _____ / _____ / _____

Address: _____

Day Phone #: (____) _____

City, State Zip: _____

Evening Phone #: (____) _____

Persons/organizations authorized to release the PHI:	Persons/organizations authorized to receive the PHI:
<input type="checkbox"/> Upper Great Lakes Family Health Center	_____ Name of Person/Organization to Receive PHI
301 Explorer Street Address	_____ Address
Gwinn, MI 49841 City, State, Zip	_____ City, State, Zip
(906) 372-3241 (906) 372-3230 Medical Records Phone # Medical Records Fax #	Phone #: (____) _____ Fax#: (____) _____

Information to be released (please check all that apply)

<u>Dental Records</u>	<u>Physician Office Records:</u>
Date of Service: _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ <input type="checkbox"/> Dental Visit Notes <input type="checkbox"/> X-ray Report(s)/Films <input type="checkbox"/> Radiographs <input type="checkbox"/> Prescription Information <input type="checkbox"/> Lab Results <input type="checkbox"/> Dental Consultation Report <input type="checkbox"/> Dental Chart Summary <input type="checkbox"/> All Records <input type="checkbox"/> Other: _____	Date of Service: _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____ <input type="checkbox"/> Office Note <input type="checkbox"/> Problem List <input type="checkbox"/> Lab(s) Report <input type="checkbox"/> Medication List <input type="checkbox"/> X-ray(s) Report <input type="checkbox"/> Referral Report <input type="checkbox"/> Immunization Record <input type="checkbox"/> All Records <input type="checkbox"/> Other: _____

I specifically mean this to include any information regarding HIV/AIDs, Drug or Alcohol use/abuse, Mental Health and other records in accordance with federal regulations. Please cross out any that do not apply.

Specific purpose of the disclosure (please check one): Continuing care Insurance Personal Legal
 Other: _____

This authorization will expire: One (1) year from the date of your signature below
[Indicate a date (e.g., December 31, 2010) or an event relating to the purpose of the authorization (e.g., "rejection of my life insurance application")]

Important Information About Your Privacy Rights

I have read and understood the following statements about my privacy rights:

- * I may revoke this authorization at any time prior to its expiration date by notifying the Director of Medical Records in writing, but the revocation will not have any effect on any actions Upper Great Lakes took in reliance on this authorization before it received my revocation.
- * I may request a copy of this signed authorization from the Medical Records Department.
- * I am not required to sign this authorization in order to receive treatment.
- * I understand there may be a fee to process this release of information.
- * Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer protected by the federal privacy regulations.

Individual's Signature

Date

If the authorization is being signed by a personal representative of the individual (such as a parent of a child under the age of 18), a description of their authority to act for the above named individual must be included.

Type/Print Name of Personal Representative

Personal Representative's Signature

Date