Medical Records
301 Explorer Street
Gwinn, MI 49841
Phone: (906) 346-9275 | Fax: (906) 372-3230
Email: him@uglhealth.org

Patient Authorization for Disclosure of Health Information

(Patient Name) _____ (Date of Birth) _____ (Maiden/Previous Name) _____ (Patient Phone #) _____

Records to Be Disclosed From:

Organization/ Individual: _____
Address: _____
_____
Phone: _____
Fax: _____

Disclose Records To:

Organization/ Individual: _____
Address: _____
_____
Phone: _____
Fax: _____

Covering the Period of Healthcare from:

Date(s): _____ to _____

OR

☐ All Past/Present Health Information

Information to Be Disclosed:

- ☐ Entire Health Record
- ☐ Medical Progress Note(s)
- ☐ Immunization Record
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Dental Record(s)
- ☐ Dental Imaging
- ☐ Other: _____

Purpose of Disclosure (check all that apply):

- ☐ At the Request of Patient
- ☐ Continued Care
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Worker's Comp
- ☐ Relocating
- ☐ Personal Use
- ☐ Other: _____

Disclosure Format:

- ☐ Fax
- ☐ Electronic (Patient Portal)
- ☐ Paper-Pickup in Person
- ☐ Paper-US Mail
- ☐ Other: _____

By signing this authorization form, I understand that:

i) The information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or other communicable diseases. It may also include information about behavioral or mental health services, treatment and/or testing for substance use disorders, and genetic testing.

1) Any sensitive information listed above I wish to be EXCLUDED will be indicated here:_____

ii) Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

iii) I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 301 Explorer Street, Gwinn, MI 49841. Revocation will not apply to information that has already been disclosed in response to this authorization.

iv) Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.

v) Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

vi) Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules

_____ _____
(Patient or Authorized Representative Signature) (Date)

_____ _____
Print Name Relationship to Patient (if applicable)

*Submit the completed form to **UGL Medical Records** via the email or fax listed at the top of this form.*

(For Office Use Only): Received On: _____ Verified By: _____