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:**
☒ Portage Health ☐ Portage Health Medical Group ☐ Upper Great Lakes Family Health Center	Name of Person/Organization to Receive PHI UPPER PENINSULA AUDIOLOGY
500 Campus Drive Address	901 W SHARON AVENUE, SUITE 9 Address
Hancock, MI 49930 City, State, Zip	HOUGHTON, MI 49931 City, State, Zip
(906) 483-1556 Medical Records Phone # (906) 483-1536 Medical Records Fax #	Phone #: (906) 523-7120 Fax#: (906) 523-7122

Information to be released (please check all that apply)

AUDIOGRAM, REPORT CHART NOTES, HEARING AID WARRANTY AND RECEIPT INFORMATION SHEET

Hospital Records		**Physician Office Records:**	
Date of Service:		**Date of Service:**	
____/____/____	☐ ED	____/____/____	☐ Office Note
____/____/____	☐ Lab(s) Report	____/____/____	☐ Problem List
____/____/____	☐ X-ray(s) Report	____/____/____	☐ Lab(s) Report
____/____/____	☐ Operative Report	____/____/____	☐ Medication List
____/____/____	☐ Inpatient Record	____/____/____	☐ X-ray(s) Report
____/____/____	☐ Discharge Summary	____/____/____	☐ Referral Report
	☐ All Records	____/____/____	☐ Immunization Record
			☐ All Records
☐ Other: ____________		☐ 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 Portage Health or 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