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)

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