McKENZIE HEALTH SYSTEM

AUTHORIZATION FORM: RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (print) _____ Date of Birth _____

By signing this Authorization Form, I understand that I am giving my authorization to McKenzie Health System's designated health information custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail, to the following person(s) or organization(s):

1. Name of person(s) or organization(s):_____

   Address: _____

   Telephone Number:_____ Fax Number:_____

   Description of information that may be used or disclosed: _____

   The information will be used/disclosed for the following purpose: _____

2. I understand the information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed when requesting psychotherapy session notes and records.

3. Authorization for release of health information is provided to the receiving party for the purpose of:
   - ☐ Treatment by another health care provider
   - ☐ Providing data for fundraising activities
   - ☐ Providing data for medical or clinical trial research
   - ☐ Employment application information
   - ☐ Providing data to be used for marketing purposes
   - ☐ Personal copy for own records
   - ☐ Evaluation of eligibility for health plan/program enrollment
   - ☐ X-ray films; Patient X-ray #_____. # of Films: X-ray___ CT____ NM___ US___ Mamms___
   - ☐ Other as indicated: _____

4. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Michigan privacy law.

5. I understand that this authorization is voluntary and I can refuse to sign the authorization. Continued or future treatment by the disclosing facility is not conditioned upon my providing this authorization unless this authorization is for providing data in connection with medical or clinical trial research. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.

6. I have the right to revoke this authorization at any time, by presenting written revocation to the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. If I am providing authorization for marketing purposes, I understand that McKenzie Health System may receive renumeration from a properly authorized business associate as a result of using or disclosing the patient's protected health information.

8. This authorization will expire in six months, unless otherwise specified.

_____ _____
Signature of Patient or Personal Representative (If signed by Legal Representative, attach a copy of document) Date

Printed Name of Patient or Personal Representative, if applicable: _____

Relationship to Patient Giving Representative Authority to Act for Patient, if applicable: _____

Witness Signature: _____ Date: _____

Expiration date: _____