CARO REGION

P.O. BOX 435, 401 N. HOOPER ST.
CARO, MICHIGAN 48723-0435

Authorization for Use or Disclosure of Information

Patient Name: ____ Date of Birth: _______________ Med. Rec. No._____________

Address: ____

Street *City* *State* *Zip*

Recipient Name:____ Telephone No.: ________________ Fax No.: __________________

Address: ____

Street *City* *State* *Zip*

I hereby authorize ____ to use or disclose the following protected health information for services rendered on ____ (date)

- ☐ Complete Copy of Chart
- ☐ Emergency Room Reports
- ☐ Operative Report
- ☐ Laboratory/Pathology Reports
- ☐ History & Physical
- ☐ Physician Notes
- ☐ Consultation Records
- ☐ Radiology Report

Other:____

Include specific description and/or any date of service limitations.

Purpose of disclosure: ____

If for patient's own purposes, the purpose may be described as "at the patient's request".

I UNDERSTAND THAT:

- The information used or disclosed pursuant to this Authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and AIDS Related Complex (ARC), as well as any medical records relating to alcohol, drug, and mental health treatment information.
- Except to the extent that McLaren Caro Region has taken any action in reliance upon this Authorization, I may revoke this authorization, in writing, at any time by sending written notice or revocation to: Heather McAllister, Privacy Officer.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this Authorization and understand that McLaren Caro Region **will not** condition continued or future treatment on whether I provide authorization. **However**, treatment **will** be conditioned on signing this Authorization if my treatment is research related or is being provided solely for the purpose of creating health information for a third party.
- I have the right to inspect or obtain a copy of the protected health information used or disclosed as permitted by applicable law.
- A photo reproduction of this Authorization shall be as valid in all respects as the original.
- This Authorization will expire in twelve months, unless otherwise specified. Expiration Date: ________________________
- If the patient is under the age of 18, a parent or guardian's signature is required.

____ ____

Signature of Patient or Personal Representative Date

____ ____

Printed Name of Patient or Personal Representative Relationship of Personal Representative to Patient

(Please provide a copy of proof of Personal Representative Status)

____ ____

Witness Date

Insurance ____ Charges ____________________________________

FORM: GEN 5
REV: 12-27-17