MRH Marlette Regional Hospital
an affiliate of
UNITED HEALTHCARE PARTNERS

2770 Main Street | P.O. Box 307 | Marlette, MI 48453
989-635-4000 | marletteregionalhospital.org

Medical Record #:_____

AUTHORIZATION: RELEASE OF MEDICAL INFORMATION

_____ _____ _____
(Patient's Name) (Date of Birth) (Social Security Number)

I authorize Marlette Regional Hospital/_____ use and/or disclosure of the above named individual's health information as follows:

1. The health information I authorize for use and/or disclosure is _____
_____.

2. I understand that this health information may include information on alcohol, drug abuse, or mental health treatment Federal Regulations Code 42, Part A. In accordance with Michigan Department of Public health code 1989, No. 174 which includes venereal disease, tuberculosis, immunodeficiency virus (HIV), acquired immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), and hepatitis.

3. This health information may be used by and disclosed to the following individual or organization:

_____
_____ _____(Phone Number)
_____ _____(Fax Number)
Address

4. Authorization for release of health information is provided to the receiving party for the purpose of:

____ Treatment by another health care provider
____ Psychotherapy or mental health treatment by another health care provider
____ Providing data for medical or clinical trial research
____ Providing data for fundraising activities
____ Providing data to be used for marketing purposes
____ Evaluation of eligibility for health plan/program enrollment
____ Employment application information
____ Other as indicated: _____.

5. Once my health information is used by or disclosed to the receiving party, it may be subject to re-disclosure or release and may no longer be protected by federal or state law.

6. I understand this authorization is voluntary and I can refuse to sign this 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 also understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.

7. 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.

8. This authorization will expire one year, unless otherwise specified. Expiration Date: _____

_____ _____
(Patient or *Patient's Legal Representative with Relationship Indicated) (Date)

_____ _____
(Witness) (Date)

Revised: 7/2015