MUNSON HEALTHCARE

Instructions for Completing HIPAA Privacy Authorization Form

This form is a fillable PDF and can be electronically completed. If you intend to type information into this form, it is important to open the form with Adobe Reader. This is necessary in order to unlock the full potential of PDF forms. If you do not have Adobe Reader, please download the free software at https://get.adobe.com/reader/

You must authorize the release of the information in writing if you would like:

- To receive a copy of your own medical record, or
- send copies to someone else, or
- have some person other than yourself to have access to your medical records.
- A Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney may not authorize release of medical information to the person named while you remain competent.

Section 1: fill in your name, address, birth date, phone number, and email. Please fill out as complete as possible, this helps to identify the correct records.

Section 2: tell us at which Munson Healthcare location(s) you had services.

Section 3: use this section to allow us to GET/retrieve records from another provider, facility, clinic, etc.

Section 4: specify what information you want us to send.

- Entire charts can be very large and contain information that is not needed for continuation of care. There may also be a charge for personal use.
- Do specify a date range, a date of service, a specific physician, a specific procedure, etc.
- If you have questions on what you should request, please feel free to contact the HIM Department at one of our locations listed at the end of the Authorization Form.

Section 5 indicate what format you want us to send:

- paper
- email with PDF
- fax
- a CD, or a USB flash drive. *The Flash drive and CD are sent encrypted unless you agree to not having these encrypted. The cost for these will be included in the fee.*

Section 6 who do you want to receive this information:

- yourself
- provider, clinic, hospital
- someone else
- Please completely fill out the address and contact information. How do you want us to send it USPS Mail, pick up in person (currently not available during Covid restrictions), encrypted Email, or fax?

Section 7 check the purpose for request; personal, continuation of care, or other.

- This does not have to be specific, though if purpose is for continuation of care, those requests will be prioritized higher than a nonspecific reason.

Section 8 sign to acknowledge you agree with the disclosure.

- If you would like the authorization to expire, please enter a date, otherwise it is valid for one year.
- We will validate your signature on file. If we do not have a recent signature we may ask for a copy of your ID, you can send a copy of your ID with your request to prevent any delays.

This form needs to be signed by the patient or by the personal representative of the patient, such as a parent if the patient is a minor.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section 1: Patient Information (please print/type)

Last Name	First Name	Middle Name	Date of Birth (MM/DD/YY)

Home Phone Number (###-###-####)	Cell Number (###-###-####)	Email address

Street Address	City	State	Zip

Section 2: I authorize Munson Healthcare facilities, clinics and providers (to include Cancer, Primary Care, etc.) to: Release information contained in my patient medical record **TO** the individuals or organizations identified in section 6 for the purposes and conditions designated on this form.

Specify which Munson Healthcare location where services were received:

____

Section 3: I authorize Munson Healthcare to get health information **FROM** this provider or facility:

☐ *SKIP SECTION 3 and proceed to SECTION 4 if you are not requesting MHC to get information FROM a provider or facility.*

Name of provider/facility: ____________ Phone #____________ Fax #____________

Address:____________

Name of provider/facility: ____________ Phone #____________ Fax # ____________

Address:____________

Section 4: **Specific Health Information to be released or disclosed:**

Provider reports & test results for dates of service from: ____________ to ____________

Complete copy of my medical record for dates of service from: ____________ to ____________ (charges may apply)

Other: (please describe) ____________ Dates of services:____________

Other: (please describe) ____________ Dates of services:____________

NOTE: *For drug and alcohol use treatment records please use form 1178 Behavioral Health and SUD Authorization for Release of Information.*

Section 5: Format ☐ Paper ☐ PDF ☐ on encrypted CD* ☐ on encrypted USB* (*may not be available at all locations)

☐ Other electronic: ____________

Section 6: Select whom to send the protected health information and how to send it

☐ **MYSELF** ☐ USPS mail (to the address listed in section 1) ☐ Fax to: ____________ (limited to 25 pages)
Area Code/Fax Number (###-###-####)

☐ Encrypted Email (listed in section 1)

☐ **SEND TO**

Other Individual/Person Name			Company/Organization
Street Address			
City	State	Zip	Phone Number (###-###-####)

☐ **FAX TO** ____________ Attention: ____________
Area Code/Fax Number (###-###-####) Name of Recipient

☐ **ENCRYPTED EMAIL TO** ____________

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☐ **Other delivery method (specify):** ______________________________

Health Information sent in an unencrypted email or on unencrypted media (DVD/flash drive) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted email or on unencrypted media, you are acknowledging and accepting these risks.

Section 7: Purpose of request/disclosure:

☐ Personal use ☐ Continuation/coordination of care

☐ Other: (please specify) ______________________________

Section 8: By signing this Authorization patient or representative understands and consents to the disclosure of the information as stated within this document and agrees to the following:

- I will not hold Munson Healthcare or its associated clinics liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- Failure to provide all information requested on this release form may invalidate this Authorization.
- I may refuse to sign this Authorization and my health care cannot be conditioned upon signing this Authorization.
- My Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.
- I can revoke (cancel) this Authorization at any time, except in circumstances in which the facility has taken actions in response to this Authorization. I understand this revocation must be submitted in writing.
- The information that I am authorizing to be released may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex). It may also include information about behavioral or mental health services, and reference a referral or treatment for alcohol and drug abuse (as permitted by CFR Part 2).

This authorization will expire one year from the date of signing or otherwise by my choice, in which case this consent will expire on: ____________________
Date

Patient/other legal guardian or personal representative signature ____________________ **Date** __________ **Time** __________

Relationship to patient ☐ if patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable

PLEASE RETURN THIS DOCUMENT TO THE APPROPRIATE LOCATION BELOW BY MAIL, FAX, EMAIL OR IN PERSON

MH Cadillac Hospital
ATTN: HIM
400 Hobart St.
Cadillac, MI 49601
Fax: 231-876-7339
Email: CAD-ROI@mhc.net

MH Grayling Hospital and
MH Paul Oliver Memorial Hospital
Fax: 312-836-7919
Email: Munson@VRCNetwork.com

Munson Medical Center
ATTN: HIM
1105 6th St.
Traverse City, MI 49684
Fax: 231-392-7308
Email: MMC-ROI@mhc.net

MH Charlevoix Hospital
ATTN: HIM
14700 Lake Dr.
Charlevoix, MI 49720
Fax: 231-547-8891
Email: CHX-ROI@mhc.net

Kalkaska Memorial Health Center
ATTN: HIM
419 S. Coral St.
Kalkaska, MI 49646
Fax: 231-935-7895
Email: KMH-ROI@mhc.net

For MH Physician office or other MH clinic records:
Submit this document directly to the office where care was received

MH Manistee Hospital
ATTN: HIM
1465 E. Parkdale Ave.
Manistee, MI 49660
Fax: 231-398-1091
Email: MST-ROI@mhc.net

MH Otsego Memorial Hospital
ATTN: HIM
825 N. Center Ave.
Gaylord, MI 49735
Fax: 989-731-6039
Email: OMH-ROI@mhc.net

INTERNAL USE ONLY

☐ Request completed by: ______________________________
Name Dept. Date

☐ Identification verified by driver's license/or other means: ______________________________
Name Dept. Date