Completed on:_____ **MR #**_____ ☐ **Given to patient** **ROI #**_____
Completed by: _____**(initials)**_ ☐ **Please mail to patient** **(HIM use only)**
Acct. #_____ ☐ **Patient will pick up**
☐ **Faxed**

825 N. Center St.
Gaylord, MI 49735
HIM Phone: (989)731-2224
Fax: (989) 731-6039

AUTHORIZATION FOR RELEASE OF INFORMATION

(Request by Patient or Patient's Representative)

I hereby authorize Otsego Memorial Hospital to disclose my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, psychological or social service records, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name **Date of Birth**

_____

Address **City** **State** **ZIP**

Date of service (if known): _____

Description of information to be released (check all that apply):
Description of the purpose of the use and/or disclosure (see examples): __

Emergency Dept_____	Physician Orders_____	Other(specify)_____
History and Physical_____	Operative Record_____	All records_____
Progress Notes_____	X-ray Reports_____	Billing Records_____
Discharge Summary_____	Nurse's Notes_____	X-ray CD_____
Consultation Report_____	Laboratory Reports_____	

_____

The health information described herein shall be released to:

Patient(Self)_____ Physician_____ Hospital_____

Attorney_____ Ins. Company_____ Other(specify)_____

I understand that this authorization will expire in 60 days from the date of signature.

I further understand that I may revoke this authorization at any time by notifying Otsego Memorial Hospital in writing I also understand that the written revocation must be dated with a date that is later than the date on this authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that my continued or future treatment by or payment to Otsego Memorial Hospital is not conditioned upon my providing or signing this authorization. I understand that I have the right to inspect or copy the health information Otsego Memorial Hospital intends to use or disclose pursuant to this authorization, and I may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

_____(initials) I have been provided with a copy of this authorization for my records.

_____

Signature of Patient or Patient's Representative **Date**

_____

Printed Name of Patient **Signature of witness**

_____ _____

Relationship to Patient OR Legal Authority (**attach supporting documentation**)