RELEASE OF INFORMATION

Medical Record # _____
(Office Use Only)

(Required items are in BOLD print — *Please do not use correction fluid or tape)*

Patient Name: _____ **Date of Birth:** ____/____/____

Previous Names: _____ **Social Security #:** ____/____/____

Address: _____ **City, State & Zip Code:** _____ **Phone #:** _____

I, _____ **authorize** _____
Name of Patient or Name of Legal Representative ***Name of Organization/Provider to Release Information***

_____ _____ _____ _____
Address ***City, State and Zip Code*** ***Phone Number*** ***Fax Number***

to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

_____
Name/Organization to Receive Information

_____ _____ _____ _____
Address ***City, State and Zip Code*** ***Phone Number*** ***Fax Number***

1. **Specific information to be disclosed** *(check all that apply)*

☐ Discharge Summary	☐ Psychological Evaluations	☐ Progress Notes	☐ Substance Abuse
☐ History & Physical Examination	☐ Lab Reports	☐ Radiology/X-ray Films	☐ Consultation Reports
☐ EKG/Stress Test	☐ Emergency Room Record	☐ Radiology/X-ray Reports	☐ Operative/Procedure Reports
		☐ Discharge Instructions	☐ Home Health

Other: _____

For the following date(s) of treatment or medical conditions: _____

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: _____

3. **I am requesting this information be released for the following purpose:**
   ☐ Continued Care ☐ Insurance Claim ☐ Personal Use ☐ Attorney Review
   ☐ Other _____
4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
5. I understand there may be a fee to process this release of information.
6. This authorization will automatically expire on: ____/____/____ or one year from the date of my signature.
7. UP Health System - Marquette will not condition my continued treatment upon my signing this authorization, except for research-related treatment.
8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.
9. I hereby agree to indemnify and hold UP Health System - Marquette, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____ _____
Patient or Patient's Legal Representative's Signature *Date*

_____ _____
**Relationship If Other Than Patient* *Witness*

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

*☐ **AUTHORITY ATTACHED** (In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization).

UP HEALTH SYSTEM MARQUETTE
A Duke LifePoint Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION