UP HEALTH SYSTEM PORTAGE

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Job #: _____

MR #: _____

ID Checked: Initials:_____

Information About the Use or Disclosure

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below:

Individual's Name: _____
(Print or type full name)

Previous Name: _____ Date of Birth: ____/____/____

Address: _____ Day Phone #: (____) _____

City, State Zip: _____ Evening Phone #: (____) _____

Persons/organizations authorized to release the PHI:	**Persons/organizations authorized to receive the PHI:**
☐ UP Health System Portage ☐ UP Medical Group Portage	_____ Name of Person/Organization to Receive PHI
500 Campus Drive Address	_____ Address
Hancock, MI 49930 City, State, Zip	_____ City, State, Zip
Phone #: (906) 483-1556 Fax#: (906) 483-1536	Phone #: Fax#: ( )

Information to be released (please check all that apply)

Hospital Records

Date of Service:

_____/_____/_____	☐ ED
_____/_____/_____	☐ Lab(s) Report
_____/_____/_____	☐ X-ray(s) Report
_____/_____/_____	☐ Operative Report
_____/_____/_____	☐ Discharge Summary
_____/_____/_____	☐ Pathology Report
_____/_____/_____	☐ History & Physical
_____/_____/_____	☐ Other (Specify)

_____

Physician Office Records:

Date of Service:

_____/_____/_____	☐ Office Note
_____/_____/_____	☐ Problem List
_____/_____/_____	☐ Lab(s) Report
_____/_____/_____	☐ Medication List
_____/_____/_____	☐ X-ray(s) Report
_____/_____/_____	☐ Referral Report
_____/_____/_____	☐ Immunization Record
_____/_____/_____	☐ Other (Specify)

_____

I specifically mean this to include any information regarding HIV/AIDs, Drug or Alcohol use/abuse, Mental Health and other records in accordance with federal regulations. Please cross out any that do not apply.

Specific purpose of the disclosure (please check one): ☐ Continuing care ☐ Insurance ☐ Personal ☐ Legal
☐ Other: _____

This authorization will expire: One (1) year from the date of your signature below
(Indicate a date (e.g., December 31, 2017) or an event relating to the purpose of the authorization (e.g., "rejection of my life insurance application"))

Important Information About Your Privacy Rights

I have read and understood the following statements about my privacy rights:

* I may revoke this authorization at any time prior to its expiration date by notifying the Director of Medical Records in writing, but the revocation will not have any effect on any actions Portage Health took in reliance on this authorization before it received my revocation.
* I may request a copy of this signed authorization from the Medical Records Department.
* I am not required to sign this authorization in order to receive treatment.
* I understand there may be a fee to process this release of information.
* Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer protected by the federal privacy regulations.

Patient's Signature_____ Date____/____/____

If not signed by patient, please indicate relationship:

(Please Circle One) Parent Legal Guardian Personal Representative

Print_____ Signature_____ Date____/____/____