SPARROW HEALTH SYSTEM

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Authorization for Disclosure of Protected Health Information

Patient's Name: _____ Birth date: _____

Address: _____ Phone No.: _____

City/St/Zip: _____ SSN: XXX-XX- _____

1. I authorize and request Sparrow Hospital (or _____) to use or make a disclosure of my protected health information, including as applicable:

   Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.

   Information about human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information:
   - ___X___ Receiving party or agency (insert name and address)
     Legal-Ease Digital Imaging, LLC PO Box 1017, Flint, MI 48501-1017
     Ph: 855-534-4003 Fax: 810-547-4030 Email: pat.legalease@gmail.com
   - _____ Sparrow Marketing Department
   - _____ Sparrow Foundation

3. Specific Type of information to be used or disclosed:
   - _____ Problem list
   - _____ Medication list
   - _____ List of allergies
   - _____ Immunization record
   - _____ Most recent history and physical
   - _____ Most recent discharge summary
   - _____ Laboratory results from (date)_____ to (date)_____
   - _____ X-ray & imaging reports from (date) _____ to (date) _____
   - _____ Consultation reports from (doctors' names) _____
   - _____ Entire record
   - _____ Other _____

   Dates of service: _____
   Time of service: _____
   ___Sparrow ___Clinton ___ Ionia ___Sparrow Specialty Hospital

4. This information may be used and disclosed for the following purposes:
   - _____ Patient use
   - ___X___ Attorney use
   - _____ Marketing use
   - _____ Fundraising use
   - _____ Other use _____

5. This authorization permits the use and disclosure of health care information for marketing purposes as described above. ☑ **NO** ☐ **YES**

   If the answer above is YES, Sparrow ☐ **WILL** /☐ **WILL NOT** receive remuneration from a third party for the use of this protected health information.

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.

8. I understand that I may revoke this authorization at any time by notifying Sparrow Hospital (or _____ _____) in writing by sending a letter to the attention of the Health Information Management Department (or _____). However, the revocation will not be valid if Sparrow Hospital (or _____ _____) has taken action in reliance on this authorization.

9. This authorization expires on (date or event) _____ or 90 days from date of the signature below.

_____
Printed name of patient or patient's representative

_____ _____
Signature of patient or patient's representative Date

10. Complete only if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date

_____
Printed name of witness

_____ _____
Signature of witness Date

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

11. Sparrow has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

_____ _____
Associate name and signature Date