War Memorial Hospital
500 Osborn Blvd
Sault Ste Marie, MI 49783

**** Items that must be completed for this authorization to be valid.**

****Patient Name:** _____ ****Birthdate:** _____

Previous Names: _____ Phone Number: _____

Address: _____ City, State & Zip Code: _____

****I authorize **War Memorial Hospital (WMH), WMH owned Physician Practices OR** _____ **(Other Facility Name)**
to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

_____ _____
Name/Organization to Receive Information Phone Number

_____ _____
Address City, State and Zip Code

****Specific information to be disclosed (check all that apply or describe the information):**

☐ Discharge Summary ☐ Psychological Evaluations ☐ Progress Notes ☐ Substance Abuse
☐ History & Physical Exams ☐ Lab Reports ☐ Xray Reports ☐ Consultation Reports
☐ EKG/Stress Test ☐ Emergency Room Record ☐ Discharge Instructions ☐ Operative/Procedure Reports
☐ Other: _____

Medical conditions or approximate date(s) of treatment: _____

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:

_____

****I am requesting this information to be released for the following purpose:**

☐ Continued Care ☐ Insurance Claim ☐ Personal Use ☐ Attorney Review ☐ PCI ☐ Clinical Review
☐ Other _____

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.

I understand there may be a fee to process this release of information.

This authorization will automatically expire on: _____ **OR** one year from the date of my signature.

WMH and all WMH owned physician practices will not condition my continued treatment upon my signing this authorization, except for research-related treatment.

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.

I hereby agree to indemnify and hold WMH and all WMH owned Physician Practices, 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 Time

_____ _____
Print Legal Representative's Name and Relationship Witness

REASON PATIENT IS UNABLE TO SIGN: ☐ MINOR ☐ DECEASED ☐ OTHER: _____

☐ AUTHORITY ATTACHED (In non-emergency situations documentation of legal representative's authority to sign for the patient must be included).

* M R - R O I *

WAR MEMORIAL HOSPITAL AND WMH PHYSICIAN PRACTICES
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Office Use Only
MR# _____