Ingham Regional Medical Center
LANSING, MICHIGAN 48910

PATIENT'S AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form for Authorization for Release of Protected Health Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or state laws respecting confidentiality of records and patient communications with mental health professionals, other healthcare providers and medical center support staff. I hereby authorize Ingham Regional Medical Center to use or disclose the specific information described below, only for the purposes and to the parties described below.

Patient's Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Social Security No._____ Telephone_____ Birthdate_____

The undersigned hereby authorizes Ingham Regional Medical Center to release any and all information contained in the records of the patient listed above, INCLUDING INFORMATION REGARDING DRUG AND/OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST, OR PSYCHIATRIST, AND HIV/AIDS/AIDS-RELATED COMPLEX DOCUMENTATION, to the individual(s) or organization(s) listed below.

Name of person(s) or organization(s) to whom disclosure is to be made:

Name _____

Address _____

Description of the specific information [include date(s) of service] to be used or disclosed_____
_____
_____

This information is being requested for the following purpose(s):
_____ At the request of the individual
_____ Other, describe: _____
_____
_____

This authorization is subject to revocation at any time, except to the extent that Ingham Regional Medical Center or its staff have already taken action in reliance upon it. I may revoke this authorization in writing by contacting Medical Records (information from medical record) or Patient Accounts (information from billing record) at the address below. Unless earlier revoked, consent will expire 60 days from date signed.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

I understand that I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I understand that Michigan law allows IRMC to charge a reasonable fee for the requested copies from the medical record.

I understand that if I am authorizing the release of protected health information not created by IRMC that IRMC cannot verify the accuracy or completeness of records created by other providers.

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

_____ _____
Signature of PATIENT or PATIENT'S LEGAL REPRESENTATIVE Date

If signed by a legal representative, indicate his/her relationship to the patient (parent, guardian, etc.) and attach legal documentation:

_____ _____
Witness to Signature Date

Ingham Regional Medical Center
401 West Greenlawn Avenue
Lansing, Michigan 48910

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