MIDMICHIGAN MEDICAL CENTER - ALPENA
PATIENT'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
REQUEST TO **RELEASE** RECORDS

This form for Authorization for Release of Medical Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or State and Federal laws respecting privacy and confidentiality of records and patient communications with mental health professionals, other healthcare providers, and hospital support staff.

Patient's Name: _____ _____
Last First Middle Initial Birthdate

Address: _____ _____
Street City State Phone

The undersigned hereby authorizes **MidMichigan Medical Center – Alpena** to release information contained in the records of the patient listed above.

☐ Yes ☐ No THIS INCLUDES 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 AS INDICATED HERE: _____.

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

_____ _____
Name Address

Include dates of treatment and specific documents to be disclosed: _____

_____

_____

PURPOSE AND NEED FOR SUCH DISCLOSURE:
☐ Continued Care ☐ Patient Request ☐ Insurance ☐ Attorney ☐ Court
☐ Other
_____

Expiration Date __/__/__. Unless specified covers a 90-day period from the date of this authorization.

Right to Terminate or Revoke Authorization

This authorization is subject to revocation at any time, except to the extent that MidMichigan Medical Center - Alpena staff have already taken action in reliance upon it. You may revoke or terminate this authorization by submitting a written revocation to MidMichigan Medical Center - Alpena. You should contact Health Information Management to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal privacy regulations.

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

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

_____ _____
Witness to Signature Date

Medical Record #_____ID Verified _____ Hand Carried_____ Faxed to#_____

Date Mailed _____ $_____pd Initial Completed By:_____