MUNSON HEALTHCARE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section 1: Patient Information (please print/type)

Last Name	First Name	Middle Name	Date of Birth (MM/DD/YY)

Home Phone Number (###-###-####)	Cell Number (###-###-####)	Email address

Street Address	City	State	Zip

Section 2: I authorize Munson Healthcare facilities, clinics and providers (to include Cancer, Primary Care, etc.) to: Release information contained in my patient medical record **TO** the individuals or organizations identified in section 6 for the purposes and conditions designated on this form.

Specify which Munson Healthcare location where services were received:
Munson Northwood

Section 3: I authorize Munson Healthcare to get health information **FROM** this provider or facility:

☐ *SKIP SECTION 3 and proceed to SECTION 4 if you are not requesting MHC to get information FROM a provider or facility.*

Name of provider/facility: _____ Phone #_____ Fax #_____

Address:_____

Name of provider/facility: _____ Phone #_____ Fax # _____

Address:_____

Section 4: Specific Health Information to be released or disclosed:

Provider reports & test results for dates of service from: Last 3 ~~to~~ years

Complete copy of my medical record for dates of service from: _____ to _____ (charges may apply)

Other: (please describe) _____ Dates of services:_____

Other: (please describe) _____ Dates of services:_____

NOTE: *For drug and alcohol use treatment records please use form 1178 Behavioral Health and SUD Authorization for Release of Information.*

Section 5: Format ☐ Paper ☐ PDF ☐ on encrypted CD* ☐ on encrypted USB* (*may not be available at all locations)

☒ Other electronic: Fax

Section 6: Select whom to send the protected health information and how to send it

☐ **MYSELF** ☐ USPS mail (to the address listed in section 1) ☐ Fax to: _____ (limited to 25 pages)
Area Code/Fax Number (###-###-####)
☐ Encrypted Email (listed in section 1)

☐ **SEND TO**

Other Individual/Person Name	Company/Organization
Caitlin Schmidt	Traverse Bay Internal Medicine

Street Address
4977 Skyview Court

City	State	Zip	Phone Number (###-###-####)
Traverse City	Mi	49684	231-486-5516

☒ **FAX TO** 231 421 1439 (Area Code/Fax Number (###-###-####)) Attention: Caitlin Schmidt (Name of Recipient)

☐ **ENCRYPTED EMAIL TO** _____

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☐ **Other delivery method (specify):** _____

Health Information sent in an unencrypted email or on unencrypted media (DVD/flash drive) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted email or on unencrypted media, you are acknowledging and accepting these risks.

Section 7: Purpose of request/disclosure:

☐ Personal use ☒ Continuation/coordination of care

☐ Other: (please specify) _____

Section 8: By signing this Authorization patient or representative understands and consents to the disclosure of the information as stated within this document and agrees to the following:

- I will not hold Munson Healthcare or its associated clinics liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- Failure to provide all information requested on this release form may invalidate this Authorization.
- I may refuse to sign this Authorization and my health care cannot be conditioned upon signing this Authorization.
- My Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.
- I can revoke (cancel) this Authorization at any time, except in circumstances in which the facility has taken actions in response to this Authorization. I understand this revocation must be submitted in writing.
- The information that I am authorizing to be released may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex). It may also include information about behavioral or mental health services, and reference a referral or treatment for alcohol and drug abuse (as permitted by CFR Part 2).

This authorization will expire one year from the date of signing or otherwise by my choice, in which case this consent will expire on: _____ (Date)

Digital signatures not available at this time. Please print and sign by hand. This message will not appear when printed.

Patient/other legal guardian or personal representative signature | **Date** | **Time**

Relationship to patient ☐ if patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable

PLEASE RETURN THIS DOCUMENT TO THE APPROPRIATE LOCATION BELOW BY MAIL, FAX, EMAIL OR IN PERSON

MH Cadillac Hospital
ATTN: HIM
400 Hobart St.
Cadillac, MI 49601
Fax: 231-876-7339
Email: CAD-ROI@mhc.net

MH Charlevoix Hospital
ATTN: HIM
14700 Lake Dr.
Charlevoix, MI 49720
Fax: 231-547-8891
Email: CHX-ROI@mhc.net

MH Manistee Hospital
ATTN: HIM
1465 E. Parkdale Ave.
Manistee, MI 49660
Fax: 231-398-1091
Email: MST-ROI@mhc.net

MH Grayling Hospital and MH Paul Oliver Memorial Hospital
Fax: 312-836-7919
Email: Munson@VRCNetwork.com

Kalkaska Memorial Health Center
ATTN: HIM
419 S. Coral St.
Kalkaska, MI 49646
Fax: 231-935-7895
Email: KMH-ROI@mhc.net

MH Otsego Memorial Hospital
ATTN: HIM
825 N. Center Ave.
Gaylord, MI 49735
Fax: 989-731-6039
Email: OMH-ROI@mhc.net

Munson Medical Center
ATTN: HIM
1105 6th St.
Traverse City, MI 49684
Fax: 231-392-7308
Email: MMC-ROI@mhc.net

For MH Physician office or other MH clinic records:
Submit this document directly to the office where care was received

INTERNAL USE ONLY

☐ Request completed by: *This section is for internal use only*
Name | Dept. | Date

☐ Identification verified by driver's license/or other means: _____
Name | Dept. | Date