

HIPAA Authorization for use or disclosure of Protected Health Information

Patient/Resident's Name: _____

Address: _____

Date Of Birth: _____ Last 4 digits of SS# _____

I hereby authorize _____ to make disclosure of my protected health information as indicated below:

THIS INFORMATION IS TO BE DISCLOSED TO:

(Name of person/title or facility to receive health information)

(Street address, city, state, ZIP code)

Description of health information to be disclosed (include dates): _____

Purpose for the Use or Disclosure of Health Information:

- Disclosures are made at the request of the patient/resident
- Other (please specify): _____

I understand that by signing this authorization:

- I understand that disclosure may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection< Acquired Immune Deficiency Syndrome or Aids-Related Complex) and any other communicable disease. It may also include information about mental health service and treatment for alcohol and drug abuse as permitted by MCL 330.1748, 42CFR Part 2, P.A. 47 of 2004, and P.A. 368 of 1978.
- I understand that this authorization is voluntary. Oakland Regional Hospital/Oakland Nursing Center will not condition its treatment or payment of me based on signing this authorization.
- I understand that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the Federal Privacy Standards.
- I understand that I may revoke this authorization by notifying the Director of Medical Records for Oakland Regional Hospital in writing of my desire to revoke it. However, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that I have a right to receive a copy of this authorization.
- This authorization will automatically expire (6) six months from date of signature OR upon occurrence of the following event that relates to me or the purpose of the intended use or disclosure about me: _____

Signature (Patient/Resident)

(Personal Representative) (Include a copy of the legal representative's authority)