ST. JOSEPH MERCY CHELSEA
SAINT JOSEPH MERCY HEALTH SYSTEM

Authorization for Disclosure of Patient Health Information From or To St. Joseph Mercy Chelsea

Patient's Name _____ Patient's Date of Birth _____

Patient's Address _____ SJMC Medical Record Number _____

City, State, Zip Code _____ Telephone Number _____

DISCLOSURE OF SJMC INFORMATION

☐ I authorize St. Joseph Mercy Chelsea to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, psychological services records, including communications made by me to a social worker, psychologist, or other practitioner, to the individuals or organizations listed below, only under the conditions listed below. I understand that St. Joseph Mercy Chelsea will not condition my treatment on my signing this authorization.

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

Address

City, State, Zip Code

IF REQUESTING SJMC INFORMATION, RETURN THIS FORM TO:
St. Joseph Mercy Chelsea
Health Information Management Department
775 South Main Street
Chelsea, Michigan 48118-1399

TO OBTAIN NON SJMC INFORMATION

☐ I authorize

_____

_____

_____

to disclose information contained in my medical records which may include alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, information related to HIV infection or AIDS, psychological services records, including communications made by me to a social worker, psychologist, or other practitioner, to:

Dr. _____

Dept./Clinic _____

St. Joseph Mercy Chelsea
775 South Main Street
Chelsea, Michigan 48118-1399

INFORMATION TO BE DISCLOSED

- ☐ Emergency Room Records of _____
- ☐ Discharge Summary (Inpt) Date(s) _____
- ☐ History & Physical
- ☐ X-ray Reports from to
- ☐ Lab Reports from to
- ☐ Outpatient Records - Specify type & dates
- ☐ Others

PURPOSE OF DISCLOSURE

- ☐ Employer Request
- ☐ Workers' Compensation
- ☐ Attorney Inquiry/Legal
- ☐ Insurance Claim/Application
- ☐ Disability
- ☐ Social Service
- ☐ Continuation of Care/Consultation
- ☐ Patient's Own Use
- ☐ Other: (specify) _____

I understand that once information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Notice Of Federal And State Laws Regarding Further Disclosure To The Person Or Organization Receiving Information: This information may have been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal regulations (42 CFR, part 2) and State law (Public Act 258, Chapter 7, section 748) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

REVOCATION CLAUSE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to St. Joseph Mercy Chelsea, Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Date six months subsequent to signing _____ Event _____

Condition _____ Other _____

SIGNATURE

Signature _____ Date _____ Time _____
(patient, parent, legal representative)

Relationship _____

IMPORTANT: ALL APPROPRIATE SECTIONS ABOVE MUST BE COMPLETED AND COPY GIVEN TO THE PATIENT