

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, **DOB:** _____ hereby authorize **BRIGHTON HOSPITAL**, its President, Designee or Health Information Services to:

*** [Initials Required:]**

1. RELEASE Information To _____ OBTAIN Information From _____ EXCHANGE Information With _____

Name: _____ Organization: _____

Street Address: _____ Relationship: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Other: _____

I understand that information contained in my health record may include alcohol and drug abuse records protected under 42 Code of Federal Regulations, Part 2; psychological services records, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC.

I understand that my protected health information (PHI) disclosed under this authorization may be re-disclosed by the individual or organization named above and its privacy may no longer be protected by law.

2. Specific type of information to be disclosed:

*** [INITIAL all types of information that apply to person/organization listed above.]**

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Contact |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> AMA Alert |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Financial/Insurance Information |
| <input type="checkbox"/> Admission Assessment | <input type="checkbox"/> Acceptance of Special Deliveries |
| <input type="checkbox"/> Treatment Plans and Reviews | <input type="checkbox"/> Admission/Discharge Letter (dates only) |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Completion of Program Letter |
| <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Completion of Benefit Forms |
| <input type="checkbox"/> Lab Results and Urine Drug Screen | <input type="checkbox"/> Other, Specify: _____ |
| <input type="checkbox"/> Psychiatric Evaluations & Medication Reviews | |

3. Purpose and need for such disclosure:

*** [INITIAL all the purposes and needs that apply to person/organization listed above.]**

- | | | |
|---|---|---|
| <input type="checkbox"/> Aftercare Planning | <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> School | <input type="checkbox"/> Payment of Bill |
| <input type="checkbox"/> Court/Probation | <input type="checkbox"/> Family Involvement / Therapy | <input type="checkbox"/> Employer Request/Job Stability |
| <input type="checkbox"/> Disability/FMLA Benefits | <input type="checkbox"/> Other, Specify: _____ | |

- This authorization may be revoked by me at any time, except in legal action cases, by my written notice to the above named individual or organization, except to the extent that the person or organization that is to make the disclosure has already taken action in reliance on my authorization.
- This authorization is effective on the date below and will expire in 6 months if not previously revoked by me in writing.
- Brighton Hospital will not condition treatment, payment, enrollment or benefit eligibility on my signing this document.
- I am voluntarily signing this authorization and understand what information is going to be released to the above named individual or organization. A copy of this authorization will be provided to me at my request.

Patient Signature

Date

Parent/Legal Representative

Date

Witnessed by

Date

Authorization For Release of Protected Health Information (PHI) Form Instructions

Brighton Hospital

Protected health information can be released to anyone that the patient authorizes in writing to receive such information.

A valid authorization MUST contain the following information or the request will be invalid and will be returned:

1. Patient's full name and date of birth (list any other names the patient may have had).
2. Patient's **initials in section # 1** which specifies what action is to be taken (Release, Obtain or Exchange protected health information).
3. To whom the information is to be sent: Name, Mailing Address and Telephone for verification that PHI is released to the correct party and Fax Number, if PHI is to be faxed.
4. Patient's **initials in section #2**, selecting the specific types of information to be sent. **Initial ONLY the types of PHI requested.**
5. Patient's **initials in section #3**, selecting the purpose and need for the disclosure. If more than one purpose and need is selected, **initial ONLY the purposes and need for disclosure that apply.**
6. The patient or patient's legal representative's signature. Authorizations signed by a legal representative must be accompanied by the guardianship documents or power of attorney documents.
7. Date of the signature.

Please contact the department at (810) 225-2581 regarding obtaining patient information of a deceased patient or if you have any questions regarding your request.

Authorization forms may be mailed or faxed to Health Information:

Attn: Health Information Dept.
Brighton Hospital
12851 Grand River Rd.
Brighton, MI 48116

or

Fax (810) 220-5519