HURLEY MEDICAL CENTER

For HMC Staff Use Only:

Patient MR#: _____

Release Date/By: _____

Authorization for Release of Health Information

Hurley Mental Health Associates, 1085 S. Linden Road, Suite 150, Flint, MI 48532

IMPORTANT: If any section is incomplete, this form becomes invalid. Please allow up to 30 days to process this release.

Name: _____ Previous Name(s): _____
Address: _____ Apt #: _____
(street)
_____ Date of Birth: _____ Phone: _____
(city, state, zip)

Release Information From:	☐ Hurley Medical Center (HMC), 1 Hurley Plaza, Flint, MI 48503 /Hurley Mental Health Associates Record ☐ Other: _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Release Information To:	☐ Hurley Medical Center (HMC), 1 Hurley Plaza, Flint, MI 48503/Hurley Mental Health Associates Record ☐ Other: _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Health Information to be Released:	Dates Requested From: _____ To: _____ (specific date range required mm/dd/yyyy) ☐ Clinic Notes ☐ Immunizations ☐ Sleep Medicine ☐ Radiology Report ☐ Hospital Records ☐ Medications ☐ Laboratory ☐ Radiology Image ☐ Prenatal Records ☐ EKG ☐ Pathology Report ☐ Billing Records ☐ Other (please specify): _____ ☐ Purpose: _____ I understand the records to be relased may include information related to evaluation or treatment of behavioral health, alcohol and drug abuse, and HIV/AIDS. I understand this authorization releases records for dates requested above and may include records prepared or collected by the facility prior to the date of signature on this authorization and/or may include records prepared or collected by the facility after the date of the signature on this authorization.
Type of Release:	Paper: ☐ Mail ☐ Pick Up ☐ Fax (limitations may apply) Electronic: ☐ Patient Portal (limitations may apply)
Revocation	I understand I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization:	I understand authorizing the release of this information is voluntary. I understand I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.542. I understand any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. This authorization will expire on _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months. If I have questions about disclosure of my health information, I may contact the facility's Privacy Officer. I understand the facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form: _____ _____ Signature of Patient or Authorized Representative Date of signature _____ _____ Printed Name of Authorized Representative Relationship to Patient or Description of Legal Authority **(documentation of legal authority required)**

Submit completed form to any HMC location, mail to Hurley Medical Center, 1 Hurley Plaza, Flint, MI 48503 or fax to 810.262.6409, Attention – Release of Information