Ascension Michigan

Patient Full Name ______________________ Maiden / Other Name ______________________

Patient Address ____

Street City State Zip

Patient Date of Birth ______________________

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________ hereby authorize **Ascension Michigan**, its Director or Designee, or Health Information Management/Medical Records Department ("Ascension Michigan"), to release the protected health information described below (**"PHI"**). The PHI may include information about: alcohol and drug abuse treatment (protected by the Federal "Part 2 Regulations"); behavioral or mental health services; and/or communicable diseases and infections, such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

1. Name of person(s) or organization(s), to whom the PHI is to be released to:

   Name U.S. Legal Support, Inc.

   Street Address 200 W. Jackson Boulevard, Suite 600

   City Chicago State IL Zip Code 60606

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy may no longer be protected by the law.

2. The purpose of the use or disclosure is:

   ☐ For ______________________; **OR**

   ☐ At my request

3. The following PHI is to be disclosed:

   ***Initial* next to the type of record to be disclosed.**

Type of Record	Date(s) of Service
____ER Report	______________
____Initial Assessment	______________
____Inpatient Summaries	______________
____Medication Evaluation	______________
____X -ray Reports	______________
____Laboratory Tests	______________
____Operative Reports	______________
____Psychiatric Evaluation	______________
____Discharge Summary	______________
____Entire Medical Record	______________
____Office Records	______________
____Immunization Records	______________

____Other – Describe records required and give approximate date(s) of service:

____

____

4. This Authorization may be revoked at any time, by writing to Ascension Michigan at: ______________________, except to the extent that information has already been released or disclosed.
5. Ascension Michigan does not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based upon this Authorization or its revocation.
6. This Authorization will expire (select one):
   - ____ When the purpose for the use or disclosure (as specified in Section 2) has been achieved.
   - ____ Upon ninety (90) days after the date signed below.
   - ____ On ____________[date].

Signature of Patient______________________ **Date** ______________

If patient is incapable or is a minor, signature of parent, guardian, patient advocate or personal representative is required.

Name: ______________________

Signature ______________________ Date______________

Relationship______________________

Address ______________________

Phone Number______________________