COVENANT HealthCare

MRN# _____

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF00366 (R 7/08)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth _____
(Full Name of Patient - Print Clearly)

Address _____ Phone _____

City _____ State _____ Zip _____

1. I give permission for the use or disclosure of the protected health information (PHI) for the patient named above. This PHI will be used as described below:
2. The following person or business is allowed to disclose the PHI:
   Covenant HealthCare, _____
   _____
   _____
3. The type and amount of information to be used or disclosed is as follows: (If needed, include dates of service)

☐ Anesthesia Record and Operative Report	☐ Medication list
☐ List of allergies	☐ Immunization record
☐ Most recent history and physical	☐ Most recent discharge summary
☐ Laboratory results	☐ X-ray and imaging reports
☐ Consultation reports	☐ Entire record
☐ Other _____	

Dates of Service Requested: _____

4. I know that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and care for alcohol and drug abuse.
5. This information may be disclosed to and used by the following person or business:
   _____
   Address: _____
   for the purpose of: _____
6. I know I have the right to revoke this permission at any time. I know that to revoke this permission I must do so in writing and give my written revocation to the Health Information Management Department. I know the revocation will not apply to PHI that has already been disclosed in response to this authorization form. I know the revocation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy. If not revoked for other reasons, this authorization will end on the following date, event or condition: _____. If I do not state an expiration date, event or condition, this authorization will end within 60 days of the date signed.
7. I know that giving permission to disclose PHI is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I know I may inspect or copy the information to be used or disclosed, as provided by law in CFR 164.524. I know any disclosure of PHI carries with it the potential for an unauthorized re-disclosure and the PHI may not be protected by federal confidentiality rules. If I have questions about disclosure of my PHI, I can contact the Privacy Officer at (989) 583-4142 or Risk Management at (989) 583-4311.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness
(You must supply a legal document on appointment)

FOR COVENANT HEALTHCARE'S USE ONLY

IDENTIFICATION OF RECIPIENT OF RECORDS:

Driver's License: _____ State Issued: _____ Expiration Date: _____

Other Picture ID: _____ Covenant Employee Badge # _____