

ACCT# _____

MR # _____

Pt. Name _____

DOB _____

SCHEURER HEALTHCARE NETWORK
170 NORTH CASEVILLE ROAD
PIGEON, MI 48755

Recd _____

Comp _____

HEALTH INFORMATION MANAGEMENT SERVICES
TELEPHONE: 989-453-5235 FAX: 989-453-4455

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I authorize Scheurer Healthcare Network to release copies of protected information in my health record to:

Name of Physician, Health Care Facility, Insurance Company, Attorney, etc. Phone Number

Street City State Zip Fax Number

Specific information to be disclosed, including treatment dates and types of reports:

PURPOSE OF RELEASE _____

I understand that this may include information relating to treatment or, but not limited to:

_____ *Alcohol and/or drug abuse, mental health, psychological services, social services

_____ *Information concerning Human Immunodeficiency Virus (HIV) test results,
Acquired Immunodeficiency Disease (AIDS) or related diseases such as
Communicable diseases and infections.

This authorization expires within (60) days. I may revoke this authorization at any time by notifying Scheurer Hospital Health Information Management Services in writing, but if I do it will not have any affect on any actions taken before the revocation was received.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. The protected health information, if redisclosed, will no longer be protected by HIPAA (Health Information Portability Accountability Act.)

PATIENT NAME: (printed) _____ DOB _____

Street City State Zip Phone Number

Patient Signature (Relationship) Drivers License Date

Witness signature Date Copies were released? Yes No
Initials _____