I authorize Scheurer Hospital to release copies of Protected Health Information from the below marked facility(s):

☐ Caseville Family Medicine ☐ Elkton Family Medicine ☐ Sebewaing Family Medicine

☐ Scheurer Family Medical Center ☐ Scheurer Professional Center ☐ Scheurer Hospital

*Information is to be disclosed to: ☐ Myself ☐ Other: _____
(Name of person, Physician, Insurance Company, Attorney, etc.)

*WHAT INFORMATION:_____

*FROM WHAT DATE:_____

*I would like to receive the above information on the following format (check those that apply):

Encrypted electronic media ☐ CD ☐Portable USB ☐ Email_____(email address)

☐Paper copies to hand carry (Release only to those listed above) ☐Fax (____) _____--_____

☐Paper copies mailed to: _____
Street Address City State Zip Code

☐View on computer (by appointment) (phone (_____) _____---_____

☐Other (please explain):_____

The records listed below are protected by Federal law. If you want this information included with this release, please initial only the items to be included.

_____ 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 from the date this authorization is signed. 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 effect on any actions taken before the revocation was received. There might be exceptions to revoke this authorization, please read your Notice of Privacy Practices to discover your revocation rights and exceptions to revocation. Treatment, payment, enrollment, or eligibility for benefits are not a condition of a signature on this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. Redisclosed protected health information, once released as requested from the hospital, will no longer be protected by HIPAA (Health Information Portability Accountability Act) including paper, facsimiles, or electronic media.I understand mailing paper medical records through the U.S. Postal Service includes the risk of loss or theft of the documents. By signing below, I release Scheurer Hospital & all affiliates of any and all responsibilities regarding loss or theft of any mailed documents included in this request.

*PATIENT NAME: (print) _____*DOB _____Phone (____)_____--_____

_____
*Legally Authorized Signature * (Relationship) *Drivers License * Today's Date

_____ Copies were released on___/___/___
Witness signature Today's Date Released by (Initials) _____

* This authorization is invalid if any of the starred (*) items for information are missing

HIMS STAFF ONLY:

EPIC ROI log#: _____Evident hospital ROI log#: _____ Evident clinic ROI log#: _____

Date Received: ____/____/_____ Date Completed: ____/____/_____ Evident Account # _____

Scheurer
Better Health. Better Life.

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Form# 733 *Revised: 11/16/2017*