GENESYS
HEALTH SYSTEM

One Genesys Parkway, Grand Blanc, MI 48439-8066
Phone: 810-606-5000

DEPARTMENTAL USE
Medical Record #_____
Account #_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Birth Date: _____

Patient's Address: _____ Social Security #: _____

City/State/Zip: _____

Maiden/Other Names: _____ Telephone #: _____

1. I authorize Genesys Health System or _____ to use and disclose protected health information contained in the patient record indicated above, including as applicable:
   - Communicable disease and infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC") and (specify other, if known) __
   - Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
   - Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.
2. Name and address of person or organization to whom disclosure of my protected health information is to be made; Legal Ease Digital Imaging 717 S. Grand Traverse, Suite 3 P.O. Box 1017, Flint, MI 48501
3. This authorization shall expire 120 calendar days from the date of signature or upon completion of this request.
4. I understand that I may revoke this authorization by contacting Medical Records at 810-606-5619 and requesting an Authorization Revocation form to fill out and return.
5. I understand that the right to revoke this Authorization, is not approved if:
   - Genesys Health System has taken action in reliance upon this Authorization; or,
   - If this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
6. I understand that my protected health information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my protected health information will no longer be protected by the law.
7. Specific type of information to be disclosed (include dates and type of treatment): _____
8. The purpose and need for disclosure: _____

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

Signature (Patient) _____ Date _____ Signature (Authorized Representative) _____ Date _____

Printed _____ Relationship of Authorized Representative _____

Signature (Witness) _____ Date _____

GIVE A COPY OF THE SIGNED AND DATED AUTHORIZATION TO THE INI

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Medical Record Copy Fees
$1.18 each page 1-20
$.59 each page 21-50
$.24 each page 51+
Postage additional-Invoice with recorc