1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Authorization for Disclosure of Protected Health Information

Patient's Full Name:_____ Birth date:_____

Address:_____ Phone No.:_____

City/St/Zip:_____

1. I authorize and request Sparrow Health System (or _____) to use or make a disclosure of my protected health information (PHI), including, without limitation, my name and the following, as applicable:

   Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.

   Information about human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174).

2. Person or organization authorized to receive information:

   _____ Receiving party or agency (insert name, address, email address (if known) and phone number))

   _____

   _____

   _____ Sparrow Health System Marketing Department

   _____ Sparrow Health System Foundation

3. Specific Type of information to be used or disclosed:

   Dates of service: _____

   Time of service: _____

   ☐ Sparrow ☐ Clinton ☐ Ionia

   ☐ Carson City ☐ Sparrow Specialty Hospital

   _____ Problem list

   _____ Medication list

   _____ List of allergies

   _____ Immunization record

   _____ Most recent history and physical

   _____ Most recent discharge summary

   _____ X-ray & imaging reports

   _____ Most recent operative report

   _____ Laboratory results

   _____ Consultation reports from (doctor's names)_____

   _____ Entire record

   _____ Other _____

4. This information may be used and disclosed for the following purposes:

   _____ Patient use

   _____ Marketing use

   _____ Other use _____

   _____ Attorney use

   _____ Fundraising use

5. If this Authorization permits the use and disclosure of my PHI for marketing purposes as described in Item 4 above, this Authorization also permits Sparrow Health System to receive financial remuneration from a third party for making such marketing communications. ☐ **NO** ☐ **YES**

6. This Authorization permits Sparrow Health System to receive remuneration from a third party in exchange for my PHI.
   ☐ **NO** ☐ **YES**

7. Indicate the form and format which you would like to receive your requested information.
   ☐ Paper copy ☐ Electronic copy (e.g. CD) ☐ Other _____

8. Indicate the means by which you wish to inspect or obtain a copy of the requested information.
   ☐ Fax ☐ Mail ☐ Email ☐ On-site inspection.

9. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.

10. I understand that I may revoke this authorization at any time by notifying Sparrow Health System Hospital (or _____ _____) in writing by sending a letter to the attention of the Health Information Management Department (or _____). However, the revocation will not be valid if Sparrow Health System Hospital (or _____) has taken action in reliance on this Authorization.

11. This Authorization expires on (date or event) _____ or 180 days from date of the signature below.

_____
Printed name of patient or patient's representative

_____ _____
Signature of patient or patient's representative Date Time

12. Sparrow Health System (or _____) may charge a fee for processing and copying the requested information as permitted by law.
13. Complete only if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date Time

_____
Printed name of witness

_____ _____
Signature of witness Date Time

[If the above signature is that of a patient's representative, Sparrow Health System must complete the following.]

14. Sparrow Health System has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

_____ _____
Caregiver name and signature Date Time