

Patient Name _____ Date of Birth _____
Maiden/Previous Name(s) _____
Phone _____ Last 4 digits of Social Security Number _____ (optional)
Address _____
City _____ State _____ Zip _____

I authorize my records to be released TO FROM

- | | | |
|--|--|---|
| <input type="checkbox"/> Sheridan Community Hospital
301 N Main St. PO Box 230
Sheridan, MI 48884
P: 989-291-3261
F: 989-291-3775 | <input type="checkbox"/> Sheridan Care
303 Congress St. PO Box 279
Sheridan, MI 48884
P: 989-291-5077
F: 989-291-5348 | <input type="checkbox"/> Signature Orthopaedics
by Sheridan
1525 E Beltline Ave NE Suite 101B
Grand Rapids, MI 49525
P: 616-535-7735
F: 989-263-1399 |
|--|--|---|

Send/pickup: Name/Organization _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

I authorize my record to be released TO FROM

- Send/pickup: Name/Organization _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
- Email _____
- Other _____

INFORMATION REQUESTED

From this/these date(s) of service: _____

- | | |
|---|--|
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Test Results (EKG, EEG) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-rays & Ultrasounds |
| <input type="checkbox"/> Records related to specific problem: _____ | |
| <input type="checkbox"/> Other: _____ | |

This authorization is made in accordance with federal and state laws. Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information below _____.

I understand that I may revoke this authorization at any time by sending a written revocation to Sheridan Community Hospital, except to the extent that it has taken action in reliance on the authorization.

I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state laws.

Patient or Legal Representative Signature _____ Date _____

Description of Authority to Act for Patient - Relationship to Patient _____

Witness: _____ Date: _____

Second Witness _____ Date: _____
(required if patient is unable to sign or gives verbal permission)

Verification of: Driver's License POA Guardianship Court Appointment Proof of Emancipation