SHERIDAN COMMUNITY HOSPITAL

Authorization RELEASE OF MEDICAL INFORMATION

Patient Sticker

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

☐ **Sheridan Community Hospital**
301 N Main St. | PO Box 230
Sheridan, MI 48884
P: 989-291-3261
F: 989-291-3775

☐ **Sheridan Care**
303 Congress St. | PO Box 279
Sheridan, MI 48884
P: 989-291-5077
F: 989-291-5348

☐ **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: _____

- ☐ Billing Records
- ☐ Discharge Summary
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Emergency Room
- ☐ History & Physical
- ☐ Test Results (EKG, EEG)
- ☐ X-rays & Ultrasounds
- ☐ Records related to specific problem: _____
- ☐ 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**

This authorization form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations 45 CFR Parts 160 and 164. Previous edition obsolete. PVH/HIM