MOUNT PLEASANT MEDICAL ASSOCIATES

4639 E Pickard St. Suite B
Mt. Pleasant, Michigan 48858

Authorization for Release or Disclosure of Health Information

Patient Name _____ Birthdate _____ Social Security Number _____

Address _____

Telephone Number _____ Medical Record Number _____

I authorize Mount Pleasant Medical Associates to disclose the above named individual's health information as described below.

Name of Individual, Entity/Organization and Address _____

Name of Individual, Entity/Organization and Address _____

Specific type of information to be disclosed: Date(s) of Service: _____ Type of Service: _____

☐ Admission face sheet ☐ History and physical ☐ Operative report ☐ Physician's Notes
☐ Consultation reports ☐ Discharge summary ☐ Entire Medical Record ☐ Nurse's Notes
☐ Billing records ☐ Commission On Aging Referral information
☐ Laboratory results from (date)_____ to (date)_____
☐ Diagnostic Imaging (X-Rays) reports from (date) _____ to (date) _____
☐ EKG & interpretations from (date) _____ to (date) _____
☐ Diagnostic Imaging (X-Rays) films from (date) _____
☐ Other _____

The purpose and need for disclosure:

☐ Continuation of Care ☐ Disability Determination ☐ Vocational Rehabilitation
☐ Social Service Referral ☐ Insurance Billing ☐ Legal Follow-Up
☐ School ☐ Individual Access Request ☐ Other _____

I understand that any information in my records relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse may be disclosed. Post Result Counseling completed by:_____date:_____(HIV test results only)

I understand that any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to Mount Pleasant Medical Associates. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, State Relationship to Patient _____

Signature of Witness _____ Date _____

For Individual Access Request

As provided by the Health Insurance Portability and Accountability Act (HIPAA) and applicable Michigan law, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set. Under certain circumstances Mount Pleasant Medical Associates (MPMA) may deny the patient (or other requestor) access to certain protected health information.

MPMA will respond to this request at the time submitted if possible, but may take up to thirty (30) days from the date submitted for information maintained on MPMA's main campus. Access to laboratory testing results will be allowed 24 to 48 hours after the testing is complete. For information not maintained on MPMA's main campus, MPMA may take as long as sixty (60) days to respond. The response may include the following actions: provide access to and/or copies of the requested information, request an extension before allowing access to and/or copies of the requested information, or issue a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed under applicable law.

MPMA may charge you a fee to cover the cost of labor, copying, postage, and preparing a summary of the requested information.

REVIEW SECTION:

Decision: Grant the Access Request ___ Deny the Access Request ___

☐ Reason for Denial (Non-Reviewable): _____

_____

_____

☐ Reason for Denial (Reviewable): _____

_____

_____

_____ _____

(Reviewer's signature) (Date)

If your request for access to protected health information has been denied, you may have the right to request a reconsideration of the denial decision. You must submit your request for reconsideration in writing to the Mount Pleasant Medical Associates Privacy Officer at the address at the top of page one of this form. You may obtain a *Request for Reconsideration of Denial of Access to Protected Health Information* form from the Medical Records Department.

As required by the Health Insurance Portability and Accountability Act (HIPAA), you have the right to voice your concerns about our privacy policies, procedures or actions. Mount Pleasant Medical Associates will not engage in any discriminatory or other retaliatory behavior against you because you voiced your concerns. All concerns must be submitted in writing to the Quality Improvement Department at the address at the top of page one of this form.

You may also file your concerns with the Secretary of the United States Department of Health and Human Services.