



General Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION:

I authorize the use or disclosure of my health information as follows:

Name of individual: _____ Date: _____

Address: _____

Telephone: _____ Medical Record #: _____ Date of Birth: _____

SJM Behavioral Services is authorized to make the requested *use or disclosure* of my Protected Health Information.

(Facility to release information)

The following person or class of persons is authorized to *receive* my Protected Health Information

Name and Address: **Axiom Requisition Copy Service, 447 North Canal Road, Lansing, MI 48917**

My health information will be used or disclosed for the following purpose(s) (ex: Marketing Activities, Fundraising Activities, employment determination, etc.) (To be completed by Requestor or Individual. Individual may write "At the request of the individual") _____

This Authorization applies to the following information:

- The following records or types of health information (specify date(s) of service): _____
 - Discharge Summary
 - History and Physical
 - Operative Report
 - X-Ray Report
 - Laboratory and Pathology Report
 - Emergency Room Report
 - All billing information pertaining to the following date(s) of service _____
 - All billing information pertaining to dates of service on or after _____
 - Other (please specify): _____
- Cardiopulmonary/EKG Report
- Physical Therapy Notes
- Physician Progress Notes
- Nursing Notes
- Consultation Report
- Other (Please Specify) _____

EXPIRATION:

This authorization expires: **Twelve (12) months from the date of signature**

*The following information may be in the records that I have asked to be disclosed. Saint Joseph Mercy Health System may disclose these specific pieces of information if they are part of the requested records. (Please check the box next to any information that may be disclosed. If no box is checked, this specific information may not be disclosed.)

- Information about the diagnosis and testing for:
 - HIV (Human Immunodeficiency Virus)
 - AIDS (Acquired Immunodeficiency Syndrome)
 - ARC (Aids Related Complex)
- Information about alcohol and drug treatment
- Information about mental health services and social services (including communications made by me to a social worker or mental health professional)

