



Patient Name: _____
 Date of Birth: ___/___/___ VID#: _____
 Attending Phys: _____
 Date of Service: ___/___/___ Room No. _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

<input type="checkbox"/> Mackinaw City Medical Clinic	<input type="checkbox"/> St. Ignace Medical Clinic
<input type="checkbox"/> Mackinaw City Specialty Clinic	<input type="checkbox"/> Oncology – St. Ignace
<input type="checkbox"/> Mackinac Island Medical Clinic	<input type="checkbox"/> Oncology – Cheboygan
P: 906-643-0436	F: 906-643-6504

<input type="checkbox"/> Mackinac Straits Health System	<input type="checkbox"/> Mackinac Island Emergency Department
P: 906-643-0124	F: 906-643-0373

PATIENT'S LEGAL NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **PHONE #:** _____
STREET CITY STATE ZIP

RELEASE RECORDS: TO FROM

NAME: _____ **PHONE #:** _____

ADDRESS: _____ **FAX #:** _____
STREET CITY STATE ZIP

THE PURPOSE OF THIS AUTHORIZATION APPLIES TO HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES: _____

REQUESTED RECORDS:

- LAB REPORTS *COVID results* PROGRESS / CLINIC NOTES MENTAL HEALTH RECORDS E.D. RECORDS
 RADIOLOGY – (PLEASE CHOOSE) – CD OTHER: _____

PURPOSE OF REQUEST:

- CONTINUATION OF CARE TRANSFER OF CARE OTHER: _____

INCLUDE (IN ANY):

- ALCOHOL AND DRUG ABUSE RECORDS PROTECTED UNDER REGULATION IN 42 CODE OF FEDERAL REGULATION, PART 2
- PSYCHIATRIC / PSYCHOLOGICAL SERVICE RECORDS, SOCIAL WORK RECORDS
- ANY INFORMATION REGARDING SERIOUS COMMUNICABLE DISEASE AND INFECTIONS AS DEFINED BY MICHIGAN DEPT. OF PUBLIC HEALTH CODE (ACT 368 OF 1978 AS REVISED), WHICH INCLUDES VENEREAL DISEASE, TUBERCULOSIS, HIV, AIDS, OR ARC.

AUTHORIZATION AND REVOCATION

I AUTHORIZE MSHS TO RELEASE OR OBTAIN THE INFORMATION MARKED ABOVE. I UNDERSTAND I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT OR PAYMENT. I UNDERSTAND THAT UPON RELEASE, THIS HEALTH INFORMATION IS NO LONGER PROTECTED AND HAS THE POTENTIAL TO BE REDISCLOSED BY THE RECIPIENT.

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION WILL BE VALID FOR 6 MONTHS FROM THE DATE SIGNED TO RELEASE ANY RECORDS CREATED UP TO DATE OF SIGNATURE. ANY RECORDS CREATED AFTER THE DATE OF THIS AUTHORIZATION WILL REQUIRE A NEW AUTHORIZATION. I UNDERSTAND THAT I MAY CANCEL THIS AUTHORIZATION, BY SENDING A WRITTEN REQUEST TO MSHS OR THE FACILITY THAT MSHS IS REQUESTING INFORMATION, AND THAT THE CANCELLATION WILL TAKE EFFECT WHEN MSHS OR THE OTHER MEDICAL FACILITY RECEIVES WRITTEN NOTICE.

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE	DATE
WITNESS SIGNATURE	DATE

FOR INTERNAL USE ONLY: MAIL FAX PICK-UP **CHARGES: \$** _____ **STAFF INITIALS:** _____ **DATE:** _____

Mackinac Straits Health System

1140 North State Street
 St. Ignace, MI 49781

Release/Request of Information

Form No.200.003

