UNIVERSITY OF MICHIGAN
HEALTH-SPARROW
MICHIGAN MEDICINE

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980
Fax: 517-364-3894
HIMCoordinators@UMHSparrow.org

Authorization for Disclosure of Protected Health Information

Patient's Full Name: _____ Birth Date: _____

Address: _____ Telephone Number: _____

City/State/Zip: _____

1. I hereby authorize UM Health-Sparrow (_____) to disclose my protected health information including copies of my medical record to the person or organization to receive information below.

   I acknowledge, and hereby consent to such, that the released information may contain the following:

   Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.

   Information about communicable diseases, human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC as defined by Department of Community Health rules (1989 Public Act 174).

   Receiving party or agency (insert name, address, email address (if known) and telephone/fax number)

   _____

   _____

2. **Date(s) of Service**: _____

   Location: **Hospital**: ☐ Sparrow Main ☐ Clinton ☐ Ionia ☐ Carson City ☐ Eaton ☐ Sparrow Specialty

   Other Sparrow Facility: ☐ Sparrow Urgent Care ☐ Sparrow Fast Care ☐ Sparrow Medical Group

   Address/Location: _____

   ☐ Thoracic Cardiovascular Institute ☐ Behavioral Health ☐ Herman-Herbert Cancer Center
   ☐ Sparrow Laboratories ☐ Sparrow Physician: _____

3. **Specific type of information to be used or disclosed:**

   ☐ Discharge Summary ☐ Laboratory Reports ☐ Emergency Room Records ☐ History and Physical
   ☐ Imaging Report ☐ ECHO/EKG ☐ Consultation Reports ☐ Operative Report
   ☐ Pathology Report ☐ Pulmonary Function ☐ Autopsy Report
   ☐ Other: _____
   ☐ Entire Record (includes all the above except the imaging cd/films, cardiac catheterization imaging and billing records)
   ☐ Imaging CD/Films ☐ Cardiac Cath Imaging ☐ Billing

4. The above information may be used and disclosed for the following reasons.
   ☐ Personal ☐ Insurance ☐ Medical Care ☐ Legal Matters (Attorney) ☐ Other _____

5. Indicate the format in which you would like to receive your requested information to be sent.
   ☐ MySparrow Patient Portal ☐ Electronic Copy (CD) ☐ Paper Copy ☐ Mail
   ☐ USB Flash Drive ☐ Email _____
   ☐ Fax to _____

6. I understand that:
   a. I may revoke my authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to my receiving the revocation. Further details may be found in the Notice of Privacy Practices.
   b. If the requester or receiver is not a health plan or a health care provider, the release of information may no longer be protected by federal privacy regulations and may be re-disclosed.
   c. This authorization automatically expires once the purpose for which it was signed is accomplished and/or 12 months from the date of signature

_____

Patient/Authorized Representative Signature Print Name Date