



1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Authorization for Disclosure of Protected Health Information

Patient's Name: _____

Birth date: _____

Address: _____

Phone No.: _____

City/St/Zip: _____

SSN: _____

1. I authorize and request Sparrow Hospital (or _____) to use or make a disclosure of my protected health information, including as applicable:

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 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)

2. Person or organization authorized to receive information:

Receiving party or agency (insert name and address)
C D Services, Inc. 248-476-1700

24027 Research Drive, Farmington Hills MI, 48335

____ Sparrow Marketing Department
____ Sparrow Foundation

3. Specific Type of information to be used or disclosed: _____ Dates of service: _____

____ Problem list
____ Medication list
____ List of allergies
____ Immunization record
____ Most recent history and physical
____ Most recent discharge summary
____ Laboratory results from (date) _____ to (date) _____
 X-ray & imaging reports from (date) _____ to (date) _____
____ Consultation reports from (doctors' names) _____
 Entire record
____ Other _____

4. This information may be used and disclosed for the following purposes:

____ Patient use
 Attorney use
____ Marketing use
____ Fundraising use
 Other use _____ For any and all purposes permitted or required by law.

5. This authorization permits the use and disclosure of health care information for marketing purposes as described above. NO YES

If the answer above is YES, Sparrow WILL / WILL NOT receive remuneration from a third party for the use of this protected health information.

- 6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

- 7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.

- 8. I understand that I may revoke this authorization at any time by notifying Sparrow Hospital (or _____) in writing by sending a letter to the attention of the Health Information Management Department (or _____). However, the revocation will not be valid if Sparrow Hospital (or _____) has taken action in reliance on this authorization.

- 9. This authorization expires on (date or event) 1 year from signed date or 90 days from date of the signature below.

Printed name of patient or patient's representative

Signature of patient or patient's representative

Date

- 10. Complete only if patient or representative signs by use of a mark:

Printed name of witness

Signature of witness

Date

Printed name of witness

Signature of witness

Date

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

- 11. Sparrow has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

Associate name and signature

Date