4100 Park Forest Drive
Traverse City, MI 49684

Copper Ridge SURGERY CENTER

Phone: 231-392-8900
Fax: 231-392-8973

Authorization for Release of Medical Information

(Required field if red)

1. Patient Information:

Name – Last, First, Middle Initial _____ _____ _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

MRN _____ **Birthdate** _____ **Phone #** _____

2. Information to be disclosed:

☐ Date(s) of service: _____ to _____

☐ Complete copy of records (there may be a charge for complete copies; see next page)

☐ Other: _____

3. Disclosed to (if other than patient):

Name (e.g. Insurance Co., Lawyer, Physician, etc.) _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

4. Purpose or need for disclosure (please check all that apply):

☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation

☐ Application for insurance ☐ Disability determination ☐ Patient use

☐ Other: _____

This authorization will remain in effect for (60) days unless it is revoked according to the directions provided on the reverse before that time frame has expired.

In accordance with the conditions listed above and on the reverse of this form, I authorize the use and/or disclosure of my medical information. I understand there may be a charge for copies.

Signature of Patient or Legally Authorized Representative: _____

Date: _____ *(Please print and sign)*

If signed by person other than patient, state relationship and authority to do so (see reverse for information about signatures):

Relationship to patient: _____

Patient is:

☐ Minor

☐ Incompetent / Incapacitated

☐ Deceased

Legal Authority:

☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased

☐ Personal Representative of Deceased

☐ Health Care Agent: _____

☐ Other: _____

**** PLEASE SEE PAGE 2 FOR FURTHER INFORMATION ****

FOR CRSC USE ONLY:

☐ Information released as above. Clerk signature/date: _____ _____

4100 Park Forest Drive
Traverse City, MI 49684

Copper Ridge SURGERY CENTER

Phone: 231-392-8900
Fax: 231-392-8973

Additional information regarding disclosure of patient medical information

Copper Ridge Surgery Center honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Federal HIPAA Privacy Rules. These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

No obligation to sign. You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, Copper Ridge Surgery Center may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if the authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Copper Ridge Surgery Center, Attention: Medical Records, 4100 Park Forest Drive, Traverse City, MI 49684.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they may receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Medical Records department of the Copper Ridge Surgery Center at 231-392-8900.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of medical information. If you are under the age of 18, your parent or a guardian must sign this form for you.