Three Rivers Health
PAWS/Community Adolescent Health Center and E3 Program

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH/PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person/organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I agree that a copy of this form may be as a signed original.

The following Person/Organization may □ Provide □ Receive information:

Name/Organization
_____
_____
_____
_____

Three Rivers Health – PAWS/CAHC and E3 Program
721 Sixth Avenue
Three Rivers, MI 49093
Office: 269-273-1418 Fax: 269-273-3347

I understand this authorization shall be valid for ninety (90) days from the date of the signature. I understand the medical information released may contain information concerning the treatment of physical or emotional illness, drug/ and/or alcohol abuse, mental health, communicable diseases, and HIV AIDS-related illness as documented.

I understand I have the right to cancel this authorization within ninety (90) days by notifying Three Rivers Health in writing. I understand the date of cancellation will be the date on which Three Rivers Health receives the request in writing. I understand that canceling this authorization will not affect any actions already completed.

INFORMATION TO BE RELEASED:

□ Partial Chart □ History & Physical
□ Entire Chart □ ER Reports
□ Laboratory Reports □ Consultation Reports
□ Radiology Reports □ Other:

REASON FOR DISCLOSURE:

□ Personal use □ Continuing Patient Care □ Insurance □Attorney/Legal □ Other:

DELIVERY METHOD:

□Mail □ Fax □ Patient/Authorized legal representative will pick up when ready

SIGNATURES:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if under 18) Date