HANNAHVILLE HEALTH CENTER
DENTAL CLINIC

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____

Name of Healthcare Provider / Physician / Facility / Medicare Contractor

_____

Street Address

_____

City State and Zip Code

Re: Patient Name: _____

Date of Birth _____ Social Security number _____

I authorize and request the disclosure of all HIPAA protected information for the purpose of review and evaluation to ensure Hannahville health Center network care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information stored on the system, EPIC Electronic Health Records, including the following:

PLEASE CHECK ANY OR ALL THAT APPLY.

- ☐ Medication list and prescription records;
- ☐ International Normalized Ratio (INR) test results;
- ☐ Any medical records related to heart disease (or heart related conditions), blood diseases, pathogens, and allergies;
- ☐ Social Security Numbers
- ☐ Tribal ID and Descendancy Paperwork or card;
- ☐ Billing Type (PRC and Direct, or Direct only); and

Other: _____

_____

I understand the information to be released or disclosed may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

_____

This authorization is given compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following health facility:

Hannahville Dental
Name of Health Facility

_____
Representative of Health Facility

N15019 Hannahville B-1 Rd.
Street Address

Wilson, MI 49896
City, State, Zip Code

I understand the following:

A. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization
B. The information released in response to this authorization may be re=disclosed to other parties.
C. My treatment or payments for my treatment cannot be conditioned on the signing of this authorization

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expired.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date