Authorization for Disclosure of Protected Health Information and Release of Medical Information Consent Form

2900 Hannah Blvd
East Lansing, MI 48823
Surgery: 517.364.8100
Weight Mgmt.: 517.364.8080

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Sparrow Medical Group-Bariatric Surgery and Sparrow Weight Management may release information over the telephone to the following persons. (i.e. blood test or x-ray results with instructions, surgery information, appointment information, etc.) If there are no names written in this section, we WILL NOT be able to release any information to anyone other than YOU.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

1. I authorize and request Sparrow Medical Group – Bariatric Surgery and Sparrow Weight Management or any of the following persons to use or make a disclosure of my protected health information **(send information to/receive information from)**. Please provide us with the name and relationship, including a telephone number if known.

- ❑ Primary Care Physician: _____
- ❑ Ob/Gyn: _____
- ❑ Cardiologist: _____
- ❑ Pulmonologist: _____
- ❑ Gastroenterologist: _____
- ❑ Endocrinologist: _____
- ❑ Spouse: _____
- ❑ Psychiatrist: _____
- ❑ Psychotherapist: (therapist, social worker, counselor) _____
- ❑ Other: _____

2. Specific types of information that cannot be disclosed:
- ❑ 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)
- ❑ None
- ❑ Other: _____

3. This information may be used and disclosed for the following purposes:
- ❑ Patient use
- ❑ Attorney use
- ❑ Marketing use
- ❑ Fundraising use
- ❑ Other

4. This authorization permits the use and disclosure of health care information for marketing purposes as described above.
- ❑ Yes
- ❑ No

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

5. 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.

6. 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 re-disclosed and no longer protected by those laws and regulations.

7. I understand that I may revoke this authorization at any time by notifying Sparrow Weight Management in writing by sending a letter to the attention of the department or office manager. However, the revocation will not be valid if Sparrow Weight Management has taken action in reliance on this authorization.

8. This authorization expires on (date or event) _____ or 365 days from date of the signature below.

_____
Printed name of patient or patient's representative

_____ _____
Signature of patient or patient's representative Date