Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ HIM # _____

Pioneer Specialty Hospital
Specialized Acute Care

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
   - □ **Pioneer Specialty Hospital – Pontiac 50 N. Perry St. Pontiac, Michigan 48342**
   - □ **Pioneer Specialty Hospital- Garden City 6245 Inkster Rd, Garden City Michigan 48135**
   - □ **Other:** _____

3. The records may be released to: Name:_____

   Address:_____

4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

□ Cardiology report(s)	□ EEG/EKG	□ Medication list	□ ED Report
□ Pathology report(s)	□ ECHO	□ List of allergies	□ Speech Therapy
□ Operative report	□ Immunization record	□ Discharge summary	□ Physical Therapy
□ History and Physical	□ Consultation report(s)	□ Laboratory reports(s)	

X-ray and imaging, ____films released_____

Records related to a specific problem of_____

5. Purpose of Disclosure:

   □ Continuing Medical Care □ Attorney/Litigation □ Insurance/Reimbursement Purposes

   □ Self/Personal Records □ Justification of disability □ Previous Medical History

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Code 42 of Regulations, Part 2.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

8. I understand and acknowledge that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 248-338-5430.

I would like a copy of this consent: □ Yes □ No Copies are to be: □ Mailed □ Picked Up □ Faxed □ E-Mail

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Signature of Witness Relationship to Patient