



916 Myrtle Avenue • Sturgis, MI 49091-2391

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby Authorize: **Sturgis Hospital for "Women's Health Center"**
Name of Facility
600 S. Lakeview; Ste. 202
Street Address
Sturgis, MI 49091
City, State & Zip Code

To Release to: _____
Name of Person and/or Agency

Street Address

City, State & Zip Code

Phone number

Please fax this release to Laurie Eagy at: **269- 659- 6746** or mail to: Sturgis Hospital – SMG Dept: L. Eagy
For questions call Laurie Eagy 269- 659- 6748 916 Myrtle Avenue
Sturgis, MI 49091

PLEASE ALLOW 48 HOURS FOR RECORDS RETRIEVAL

I wish my records to be MAILED.

I wish to be called at this number () - when my records are ready to be PICKED UP.

I hereby consent to the release and/or review of any medical information which may include the following: records of alcohol, drug abuse, psychiatric illness, and any other information regarding communicable disease and serious communicable diseases which includes venereal diseases, Tuberculosis, Hepatitis B, HIV infection, Acquired Immunodeficiency Syndrome (AIDS), or Acquired Immunodeficiency Syndrome Complex (ARC).

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

This authorization shall expire without express revocation 90 days (3 months) from the date written below OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

I have read the above and fully understand its contents in its entirety.

Signature of patient or authorized representative

Description of Authority to Act for the Individual

Date