Centegra Hospital - Michantley Centegra Physician Care Other:		PATIENT NAME:			MRN:		
Street TELEPHONE: TELEPHON				1000			
TELEPHONE: [MM/DD/YYYY] The undersigned hereby authorizes and requests: Centegra Hospital - Michenry Centegra Hospital - Woodstock Centegra Hospital - Huntley Centegra Hospital - Huntley Centegra Physician Care Contegra Soutpained Behavior Health Authorization Contegra Soutpained Behavior Health Authorization Contegra Soutpained Behavior Health Authorization Contegra Soutpained Behavior Health Physician Care C		<u> </u>			5+	ata Zin	
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The second information in formation is released information for welfare requesting records from Centegral Soutpointer Behavior Health Authorization in Refease of Information Form When requesting records from Centegral Soutpointer Behavior Health and Crist Departments. Telephone number 248-367-3330 Telephone number 248-367-3330 Telephone number 248-367-3337 Fax number HEALTH INFORMATION TO BE DISCLOSED: Date(s) of Service (if known): Demergency Department Operative Report Oradiac Diagnostic Diagnostic Report Oradiac Diagnostic Diagnostic Report Oradiac Diagnostic	그들은 아니라 아니라 아이들이 아니는 아이들이 아니라		2.700.000		MI	48086-5054	
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HEALTH INFORMATION TO BE DISCLOSED: Date(s) of Service (if known): □ Emergency Department □ Operative Report □ Immediate Care □ Billing Reports □ Hospital Abstract □ Radiology Report □ Radiology Image □ Other (specify): □ Discharge Summary □ Cardiac Diagnostic Report □ Cardiac Image □ PLEASE-SEATTAONED SUB □ Medication Records □ Therapy (PT OT ST) □ Immunizations □ OR LETTER REQUEST □ Date Results □ Purpose FOR DISCLOSURE: □ Further Care □ Insurance Claim □ Legal ■ Other PRETRIAL DISCOVERY □ If ully understand and acknowledge that my medical record may contain information relating to mental developmental disabilities, alcohol/drug abuse and/or Acquired Immune Deficiency Syndrome (AIDS)// Immunodeficiency Virus (HIV) test results or other sensitive information and Lexpressly authorize the release of an information contained in records designated above. Lunderstand that information disclosed pursuant to this author may be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws and regul Centegra Health System is not responsible for any re-disclosures of health information or medical records. As descreening Health System that diagnostic and therapeutic information may be required to process payment and disclosed to my insurance company and/or the insurance company's review agency and no authorization is required to my insurance company and/or the insurance company's review agency and no authorization is required to religibility for benefits on this authorization. □ I may inspect and arrange for photocopies of records/health care information that are to be disclosed understand that I may be responsible for costs associated with obtaining copies of my records. I may revolably the retrieval of the extent that action has been taken in good faith reliance on this authorization benefits on this authorization as the process of the photocopies of records/health care information that are to be disclosed to my inspect and arrange for photocopies of records/health care informatio	for Release of Information Form when re	equesting records					
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I fully understand and acknowledge that my medical record may contain information relating to mental developmental disabilities, alcohol/drug abuse and/or Acquired Immune Deficiency Syndrome (AIDS)/Immunodeficiency Virus (HIV) test results or other sensitive information, and I expressly authorize the release of an information contained in records designated above. I understand that information disclosed pursuant to this author may be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws and regul Centegra Health System is not responsible for any re-disclosures of health information or medical records. As describentegra's Notice of Privacy Practices, I understand and acknowledge that for the purposes of third party paym Centegra Health System that diagnostic and therapeutic information may be required to process payment and obsclosed to my insurance company and/or the insurance company's review agency and no authorization is required to disclosure unless I choose to pay for services in full and out-of-pocket at the time such services are rend understand that this authorization is voluntary and Centegra Health System will not condition treatment, payenrollment or eligibility for benefits on this authorization. I may inspect and arrange for photocopies of records/health care information that are to be disclosure unless that I may be responsible for costs associated with obtaining copies of my records. I may revolutional that the process of the extent that action has been taken in good faith reliance on this authorization but mitting a written revocation to Centegra Health System Medical Records, 527 W. South Street, Woodstock, IL 6X.	o Hospital Abstract o Discharge Summary o Medication Records	o Radiology F o Cardiac Dia o Therapy (P	Report Ignostic Report IT OT ST)	o Radiology Image o Cardiac Image o Immunizations		■ Other (specify):	
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