YOUR RIGHTS:
I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this Authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.

I understand that I may revoke this limited Authorization in writing at any time at the address found below, except to the extent that action has been taken in reliance on this Authorization. This Authorization is in effect until revoked by me or until it expires under applicable laws. An exception for registered chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.

This form should be mailed to:

☒ Saint Joseph Mercy Health System
Health Information Services Department
5301 East Huron River Drive
PO Box 995
Ann Arbor, MI, 48106-0995

❑ _____
_____
_____

_____
_____

REVOCATION OF THIS AUTHORIZATION

I hereby revoke the authorization made on _____.

_____ _____
Signature of Patient or Representative Date/Time

_____
Relationship to the patient (if Personal Representative)

This revocation should be mailed to:
Saint Joseph Mercy Health System
Health Information Services Department
5301 East Huron River Drive
PO Box 995
Ann Arbor, MI, 48106-0995