MetroHealth Hospital

Authorization For Release of Protected Heath Information

Medical Record No: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ Date(s) of Service: _____

(City, State, Zip)

INFORMATION REQUESTED:

☐ History & Physical	☐ Discharge Summary	☐ Emergency Report	☐ EEG/ECG
☐ Operative Report	☐ Lab/Path Reports	☐ Billing Invoice	☐ Blood Type
☐ Radiology Reports	☐ Progress Notes/Reports	☐ Immunizations	☐ Consults/Letters

☐ Other: _____

I would like copies of my health information indicated in the section above sent:

FROM: _____ TO: _____

_____ _____

_____ _____

_____ _____

I authorize the release of health information, contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus (HIV), HIV testing,
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC) and _____(specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

PURPOSE OF DISCLOSURE:

☐ Attorney/Legal ☐ Continued Patient Care ☐ Insurance ☐ Personal Use

☐ Worker's Compensation ☐ Other_____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization or person. I further understand that correspondence, patient discharge instructions and records from healthcare providers other than Metro Health Hospital, will not be released unless specifically requested above.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it.
Expiration date:_____ or action: _____
If no express revocation is issued, this authorization will expire in **60 days** from the date signed.

We will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization if we are seeking to use or disclose your health information for our own purposes.

I understand that Health Information that is released under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Health Information may no longer be protected by law.
* A faxed copy of this authorization shall have the same effect as the original.

_____

Signature of Patient or Legal Representative Date Relationship to Patient

Witness:_____ Date:_____ **ID CHECKED:** _____