Required Fields *

METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

* Patient Name:_____ * Date of Birth:_____

* Address:_____ * Telephone:_____

_____ * Date Received Care / Visit:_____

(City, State, Zip)

*** INFORMATION REQUESTED ***

☐ History & Physical	☐ Discharge Summary	☐ Emergency Report	☐ EKG
☐ Operative Report	☐ Lab/Path Reports	☐ Billing Invoice	☐ Discharge Instructions
☐ Radiology Reports	☐ Progress Notes/Reports	☐ Immunizations	☐ Consults/Letters

☐ Other:_____

☐ **Doctor's Office Site Record** _____

Please specify site

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

FROM: **Metro Health Hospital**
5900 Byron Center Ave. SW
Wyoming, MI 49519
Phone: (616) 252-7010
Fax: (616) 252-6965

* 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	☐ Transfer to new PCP: Dr._____		☐ Other_____

I understand the information released under this authorization may be re-released by the recipient.

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:**_____, unless otherwise stated, this authorization will expire in **180 days** from the date signed.
Treatment, payment or enrollment in a health plan will not be conditioned on signing this authorization for the covered entity's own uses.

_____ My Chart Release

_____

* Signature of Patient or Legal Representative | * Date | * Relationship to Patient if patient is a minor

Staff Only:

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

Medical Record No:_____

Payment: There may be a fee associated with this record request. Payment may be required to be paid in full prior to releasing the records.