Authorization for Release of Information

NOTE: COMPLETE ALL FIELDS TO ENSURE YOUR REQUEST CAN BE PROCESSED

Office Location: _____

I AUTHORIZE AND REQUEST the release of the specific information below for the patient listed here:

PATIENT NAME: _____

LAST FIRST MI MAIDEN OR OTHER NAME DATE OF BIRTH SS#

AUTHORIZED BY: (Patient, Parent or legal guardian) AND; I am authorized to make this disclosure:

Name: _____ Date of Birth: _____ Phone# _____ Relationship: _____

Address: _____

RELEASE FROM CURRENT PRACTICE *(WHERE YOUR RECORDS ARE COMING FROM)*:

Name: _____

Address: _____

RELEASE RECORDS TO *(THIS IHA OFFICE)*:

Name: _____

Address: _____

INFORMATION TO BE RELEASED: *(Initial Below)*

_____ Specifically any and all of the medical record information in the possession of IHA as well as any other employee, provider, nurse, nurse practitioner or any other person employed by IHA and involved in my health care;

_____ Specifically include my entire medical record including, Substance abuse, Mental Health, HIV related testing.

_____ Other: All relevant medical, inpatient, and diagnostic testing records or Specifically only

PURPOSE OF DISCLOSURE:

☐ Relocating out of area ☐ Changing doctor in area ☐ Specialist Consultation/second opinion

☐ Transfer from pediatric to adult doctor ☐ Legal ☐ School ☐ Insurance Change (Non-par)

☐ Workers Compensation ☐ Doctor's Care ☐ Nursing Staff ☐ Other Staff

1. I understand that this authorization will expire on _____ (Print the Date this form Expires) 60 days **after I have signed the form**.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign.
4. I understand that in compliance with the State of Michigan laws pertaining to record copies, I may be charged a reasonable cost based fee of $ _____. I may also be charged for each x-ray copy $15 per sheet. There is no charge for medical records if copies are sent to facilities for Specialist care, school purposes, insurance billing, or for Worker's Compensation.

_____ _____ OR _____ _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____

RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

INTERNAL USE

PRESENTED ID: _____ **VERIFIED BY:** _____ **PROOF OF LEGAL GUARDIANSHIP:** _____

PROVIDER REVIEWED: _____ **DATE:** _____ **DATE REQUEST FILLED:** _____ **BY:** _____

FEE COLLECTED: _____ **WRITTEN REQUEST TO REVOKE (ATTACH) PROCESSED BY:** _____ **EFF DATE:** _____