Trinity Health
IHA Medical Group

AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Complete ALL Fields to ensure your request is processed

Note: You will not be contacted about the status of your requests, which can take up to thirty days to process. If you have questions, you can contact us at: 734-887-8966 or Medical_records@ihacares.com

AUTHORIZE AND REQUEST THE RELEASE OF INFORMATION BELOW FOR THE FOLLOWING PATIENT:

Patient Name: _____ Date of Birth: ___/___/____ Phone: _____

Address: _____City/State/Zip:_____

Email Address: _____

RELEASE RECORDS FROM:

☐ IHA/SMNG Provider Name: _____Office Name: _____

☐ All IHA/SJMG Provider/Offices _____ ☐ Other (Be specific) _____

RELEASE RECORDS TO:

☐ **Me**: I request Trinity Health to release my protected information to Myself at the address listed above.
☐ **Other**: I am the legally authorized representative of the patient listed above and request Trinity Health to release the protected health information to:

Name: _____Company/Organization_____

Address: _____City/State/Zip: _____

Email Address: _____Fax: _____

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at law, etc. *BILLING: Billing information will be mailed to the address stated above unless otherwise specified.

INFORMATION TO BE RELEASED: (Check all that apply)

Dates of service: ___/___/___ through ___/___/___

- ☐ Office Visits
- ☐ Outside Consult Notes
- ☐ Laboratory Reports
- ☐ Imaging/Films
- ☐ Radiology Reports
- ☐ Billing Record
- ☐ Entire Record
- ☐ Other: _____

PURPOSE OF RELEASE (check reason):

☐ Continuity of Care ☐ Transfer out ☐ Insurance ☐ Legal ☐ School ☐ Personal ☐ Workers Compensation

FORMAT (Charges may apply):

Format type: ☐ Encrypted link via Email ☐ Encrypted CD (delivered by Mail) ☐ Paper Copy (delivered by Mail)

Signature: _____ Print Name: _____Date:_____

Sensitive Information: I request the following Information be released, which may include alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS, or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis, genetic information, and demographic information, for the purposes and conditions designated on this form.

Right to Revoke (cancelling) authorization: I have the right to revoke (cancel) this limited authorization in writing at any time. Revocations must be made in writing and sent to Trinity Health Release of Information with the address on the top of this form. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy or the policy itself.

Expiration: This authorization will expire in six months unless specified on the following date, event, or condition_____.

Re-disclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be re-disclosed and no longer protected by these regulations.

INTERNAL USE

PRESENTED ID: ☐ PROOF OF LEGAL GUARDIANSHIP: ☐ FEE COLLECTED: ☐ WRITTEN REQUEST TO REVOKE (ATTACH) ☐

VERIFIED BY: _____ DATE **RECEIVED:** _____

PROCESSED BY: _____ **DATE PROCESSED:** _____ **FORWARDING REQUEST TO MRO FOR PROCESSING ☐**