MetroHealth Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

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	☐ 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.

_____

Signature of Patient or Legal Representative Date Relationship to Patient

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

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