HENRY FORD HEALTH®

Authorization to Access or Release Medical Information

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

I understand that signing this authorization form means I give permission to Henry Ford Health (HFH) to disclose information about my health and healthcare. I understand that information used or released based on this authorization may also be released by the person that receives the information.

Fill out the following patient information:

First Name	Middle Name	Last Name	Maiden Name or Previous Name

Address	City	State	Zip Code

Date of Birth	Phone Number	Email Address

Reason for This Authorization

I authorize my records to be sent from the following locations (select all that apply):

- ☐ Henry Ford Behavioral Health
- ☐ Henry Ford Brighton Center for Recovery
- ☐ Henry Ford Eastwood Behavioral Health
- ☐ Henry Ford Genesys Hospital
- ☐ Henry Ford Hospital - Detroit
- ☐ Henry Ford Jackson Hospital
- ☐ Henry Ford Macomb Hospital
- ☐ Henry Ford Madison Heights Hospital (formerly Oakland)
- ☐ Henry Ford Maplegrove Center
- ☐ Henry Ford Providence Novi Hospital
- ☐ Henry Ford Providence Southfield Hospital
- ☐ Henry Ford River District Hospital
- ☐ Henry Ford Rochester Hospital (formerly Providence Rochester)
- ☐ Henry Ford St. John Hospital
- ☐ Henry Ford Warren Hospital (formerly Macomb)
- ☐ Henry Ford West Bloomfield Hospital
- ☐ Henry Ford Wyandotte Hospital
- ☐ Other (Clinic/Medical center): _____

I authorize my records be sent from:

☐ Other Facility:

Name/Organization			

Address	City	State	Zip Code

Phone Number	Fax Number

I authorize my records to be released to:

Myself (select only one option)

☐ MyChart patient portal ☐ Email address listed on first page

☐ Mailed to address listed on first page ☐ Faxed to this number: _____

☐ Mailed to a different address (include here): _____

☐ On site inspection (authorization is valid only if received by Henry Ford Health within 60 days of the date signed)

I authorize my records to be released to:

Other (complete information below to disclose to other)

Name/Organization			
Address	City	State	Zip Code
Phone Number	Fax Number		

Complete below if you want to include medical records for these services:

☐ Substance use disorder diagnosis and treatment

Purpose: ☐ Continuation of care ☐ Legal ☐ Person

☐ Psychotherapy Notes

☐ Other _____

Complete the types of records and dates of service to be released:

	Type of Record Requested	**Date of Service**
☐	Discharge Summary	
☐	Outpatient Record	
☐	Emergency Department	
☐	Radiology Report	
☐	Laboratory Report	
☐	Office Note	
☐	Immunizations	
☐	Inpatient Record	
☐	Other or all (explain):	

Authorization Details

- This authorization expires when the patient information is disclosed as permitted in this authorization, or within 1 year from the date it is signed unless another expiration date is written here: _____ (describe the date, event, or condition upon which the authorization will expire; must be no longer than 1 year from the date signed).
- My care or treatment will not be affected by signing this form.
- Henry Ford Health and its copying service reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.
- By signing this authorization, I authorize Henry Ford Health to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper or electronic format, as set forth below. Such notes may contain information on:
  - General medical care
  - Psychological and social work counseling
  - Human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), as applicable
  - Communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable
  - Demographic information
  - Treatment received by other health care providers.
  - Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records
  - Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269

How to Take Back an Authorization

- I know that I can take back (revoke) this authorization at any time.
- To take back this authorization, I understand I need to put it in writing or email form and give it to HFH.
- I understand that taking back the authorization does not apply to information that has already been released.
- To contact the HFH Information Department about taking back an authorization, email: HFHSMedicalRecords@hfhs.org

Return Completed Form

Please mail, email, or fax the completed form. Keep in mind emails sent over the internet may not be secure.

- Mailing Address: **Medical Records** 1414 E. Maple Road, Troy, MI 48083
- Email: HFHSMedicalRecords@hfhs.org
- Fax Number: (313) 916-3917

I have read and understand the authorization above. I was able to ask all my questions, and they were answered.

_____ _____ _____

Patient or Legal Representative Signature | Date | Time

_____

Relationship (if other than patient; If legal guardian, personal representative, or person of authority under a durable medical power of attorney, a copy of appropriate documents may be required)

☐ Check if interpreter was used. _____

Interpreter Name and Phone Number

HENRY FORD HEALTH℠

Request for Deceased Patient's Records

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

Michigan Law

Michigan law recognizes a patient's right to privacy of their medical information, even after death.

- You **cannot** request the deceased patient's medical records if you were only the Durable Power of **Attorney for Healthcare or Patient Advocate for the patient. These positions are automatically done** (terminated) at the time of the patient's death.
- You **can** request copies of the deceased patient's medical records if you are the court appointed Personal Representative of the patient, Beneficiary of the patient's Life Insurance, or the Heir at Law.
    - You must fill out all the information below.
    - Provide a copy of the patient's death certificate along with any other information requested below.
    - Must also include a completed Authorization to Access or Release Medical Information form.

Deceased Patient Information

Patient Name _____

Date of Birth_____ Date of Death _____

Address (Street, City, State, Zip Code) _____

Requestor Information: The requestor is the person that would like to get the patient's medical records.

Requestor Name _____

Telephone Number_____Relationship to Deceased Patient_____

Address (Street, City, State, Zip Code) _____

I am (check all that apply):

☐ The **Personal Representative** of the deceased patient.
- Include a copy of the legal document and your driver's license or state ID card.

☐ A **Beneficiary of the Life Insurance policy** of the deceased patient.
- Include a copy of the Certificate of Coverage that lists you as a named beneficiary and your driver's license or state ID card.

☐ The **Heir at Law** of the deceased patient.
- To quality as Heir at Law in the state of Michigan, I know my relationship to the deceased patient must be through natural birth or adoption.
- I have checked with all Heirs at Law of the patient (if any). Each has agreed that they do not object to getting copies of the deceased patient's medical records.
- Include a copy of your driver's license or state ID card.
- **Choose the Heir at Law statement that applies:**
    - ☐ I am the surviving **spouse** of the deceased patient.
    - ☐ I am the surviving **adult child** of the deceased patient.
    - ☐ I am the surviving **parent** of the deceased patient.
    - ☐ I am the surviving **aunt or uncle** of the deceased patient (sibling of the deceased patient's parent).
    - ☐ I am a surviving **descendant** of the deceased patient – Relationship: _____

_____ _____ _____

Requestor Signature Date Time

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