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.

First Name Middle Name		Last Name			Maiden Name or Previous Nam			
Address		City			State		Zip Code	
Date of Birth	Phone Number			Email Address				
Reason for This	Authorizatio	on						
I authorize my recor			llowing	locations (sele	ct all tha	t appl	y):	
☐ Henry Ford Behavioral Health				☐ Henry Ford Providence Novi Hospital				
☐ Henry Ford Brighton Center for Recovery				☐ Henry Ford Providence Southfield Hospital				
☐ Henry Ford Eastwood Behavioral Health				☐ Henry Ford River District Hospital				
☐ Henry Ford Genesys Hospital				☐ Henry Ford Rochester Hospital (formerly Providence Rochester)				
☐ Henry Ford Hospital - Detroit				☐ Henry Ford St. John Hospital				
☐ Henry Ford Jackson Hospital				☐ Henry Ford Warren Hospital (formerly Macomb)				
☐ Henry Ford Macomb Hospital				☐ Henry Ford West Bloomfield Hospital				
Henry Ford Madison Heights Hospital (formerly Oakland)				☐ Henry Ford Wyandotte Hospital				
☐ Henry Ford Maplegrove Center				☐ Other (Clinic/Medical center):				
I authorize my recor ☐ Other Facility:								
Name/Organization								
Address		Cit	У		Sta	ate	Zip Code	
Phone Number				Fax Number			1	

Effective Date: 11.2025

I authorize my records to be releas	ed to:					
Myself (select only one option)						
☐ MyChart patient portal	MyChart patient portal			☐ Email address listed on first page		
☐ Mailed to address listed on first	☐ Mailed to address listed on first page		☐ Faxed to this number:			
☐ Mailed to a different address (in	nclude here):					
☐ On site inspection (authorization date signed)	n is valid only if	received by Henry	Ford Health wi	ithin 60 days of the		
I authorize my records to be releas	ed to:					
Other (complete information below Name/Organization	to disclose to oth	her)				
Address	City		State	Zip Code		
Phone Number		Fax Number				
Purpose: Continuation of Psychotherapy Notes Other Complete the types of records and da						
Type of Record Requested	Type of Record Requested			7		
☐ Discharge Summary						
☐ Outpatient Record				_		
☐ Emergency Department	Emergency Department			_		
☐ Radiology Report	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

Effective Date: 08.2025

• Fax Number: (313) 916-3917

I have read and understand the authorization above. I was able to	ask all my questions, a	nd they were answered.
Patient or Legal Representative Signature	Date	Time
Relationship (if other than patient; If legal guardian, personal representational power of attorney, a copy of appropriate documents may be recommended.)	•	hority under a durable
☐ Check if interpreter was used Interpreter Name and Phone Number	er	

Page **3** of **3**