

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):

- | | |
|--|--|
| <input type="checkbox"/> Henry Ford Behavioral Health | <input type="checkbox"/> Henry Ford Providence Novi Hospital |
| <input type="checkbox"/> Henry Ford Brighton Center for Recovery | <input type="checkbox"/> Henry Ford Providence Southfield Hospital |
| <input type="checkbox"/> Henry Ford Eastwood Behavioral Health | <input type="checkbox"/> Henry Ford River District Hospital |
| <input type="checkbox"/> Henry Ford Genesys Hospital | <input type="checkbox"/> Henry Ford Rochester Hospital (formerly Providence Rochester) |
| <input type="checkbox"/> Henry Ford Hospital - Detroit | <input type="checkbox"/> Henry Ford St. John Hospital |
| <input type="checkbox"/> Henry Ford Jackson Hospital | <input type="checkbox"/> Henry Ford Warren Hospital (formerly Macomb) |
| <input type="checkbox"/> Henry Ford Macomb Hospital | <input type="checkbox"/> Henry Ford West Bloomfield Hospital |
| <input type="checkbox"/> Henry Ford Madison Heights Hospital
(formerly Oakland) | <input type="checkbox"/> Henry Ford Wyandotte Hospital |
| <input type="checkbox"/> Henry Ford Maplegrove Center | <input type="checkbox"/> 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
- Mailed to address listed on first page
- 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)
- Email address listed on first page
- Faxed to this number: _____

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
<input type="checkbox"/>	Discharge Summary	
<input type="checkbox"/>	Outpatient Record	
<input type="checkbox"/>	Emergency Department	
<input type="checkbox"/>	Radiology Report	
<input type="checkbox"/>	Laboratory Report	
<input type="checkbox"/>	Office Note	
<input type="checkbox"/>	Immunizations	
<input type="checkbox"/>	Inpatient Record	
<input type="checkbox"/>	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