HENRY FORD MACOMB HOSPITALS

Authorization to Release Medical Information

There may be a fee associated with copying of Medical Records. See reverse side for schedule.

15855 Nineteen Mile Road
Clinton Twp., MI 48038
Voice: (586) 263-2470 Fax: (586) 263-**2446**

Patient's Name: _____
(include maiden name, other names patient is known by)

Address: _____
(street) (city) (state) (zip)

_____ _____ _____
(Phone # incl. area code) **(Social Security Number)** **(Date of birth)**

Henry Ford Macomb Hospitals are authorized to *disclose* my information **to:**

_____is authorized to *receive* the information.
(person or name of organization)

_____
(street address) (city) (state) (zip)

I hereby authorize the following information to be released:

- ❑ Only Medical records about specific health care service(s):
  - ❑ **H**ospitalization **(includes inpatient, emergency and outpatient services)**, specify time period date(s): From:_____ To:_____
    Unless you specify additional information you want released, we will send the following reports: discharge summary, emergency record, history and physical exam, operative report, pathology report, lab, x-ray, EKG results.
  - ❑ Laboratory results, specify test(s) or date(s): From:_____ To:_____
    Diagnostic Reports (x-ray, EKG, etc.), specify test(s) or date(s):
    From:_____ To:_____
  - ❑ Physician Office visit(s), specify date(s): From:_____ To:_____
  - ❑ Immunizations
  - ❑ Other, specify service(s) _____and date(s) From:_____ To:_____
- ❑ Only records maintained at a specific location, specify location name(s): _____
- ❑ Any and all records

The purpose or need for the disclosure ((check one or more, if desired):

- ❑ Medical treatment/evaluation
- ❑ Insurance
- ❑ Worker's Compensation
- ❑ Disability
- ❑ Attorney request
- ❑ Other (specify)_____

I understand that, if contained in the records requested above, the following information will be included in the release:

Substance abuse information protected under the regulations in 42 Code of Federal Regulations, Part 2

Mental health treatment records, psychological services and social services information, including communications made by me to a psychiatrist, psychologist, social worker, nurse or other mental health care provider.

Information about communicable diseases, serious communicable diseases and infections as defined by statute and the Michigan Department of Public Health rules which include venereal disease "VD," tuberculosis "TB," hepatitis, human immunodeficiency virus "HI," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC."

Expiration date of this authorization:

Without expressed written revocation, this authorization expires **six months from request date.**

Your Rights:
I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this Authorization. (NOTE: Inspection and copying is not required if the disclosure is made directly to the patient.)

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may revoke this limited Authorization in writing at any time at the address found below, except to the extent that action has been taken in reliance on this Authorization. This Authorization is in effect until revoked by me or until it expires under applicable laws.

_____ _____

Signature **(Patient, parent of a minor, legal guardian or personal representative*)** **Date**

_____

Relationship to the patient

_____ _____

Signature of Workforce Member (Witness) Date

*If personal representative, a copy of the Letter of Authority from Probate Court is necessary. If legal guardian, a copy of the Court Order appointing the guardian is necessary.

Fees apply to all requestors not listed under statutory fees:
$21.20 retrieval fee/initial fee
$ 1.06 per page for the first 20 pages
$ .53 per page for pages 21 through 50
$ .22 per page for pages 51 and over
$ 1.25 per page for all microfilm/microfiche pages

Postage and shipping costs.

Patient requesting records for personal use will not be charged a retrieval fee/initial fee.

A medically indigent individual that receives copies of medical records at no charge is limited to 1 set of copies. You must provide proof that you are a recipient of assistance.

Statutory fees:
Worker's Compensation: $.25 per page; $7.00 handling; actual cost of mailing/postage
Disability Determination Services/Social Security: $15.00 FLAT FEE
Department of Social Services: 1-5 pages $5.00; 6 or more pages, $.25 per page; Postage/shipping
Continuing care requests: No charge

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