Henry Ford HEALTH SYSTEM

X MRN: _____
MEDICAL RECORD NUMBER

PATIENT INFORMATION RELEASE AUTHORIZATION

Patient Full Name: _____ Maiden Name: _____
Last First Initial

Date of Birth: _____ Last 4 digits of SS#: _____ Sex: M/F Telephone: ( ) _____

X Address: Street: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize Henry Ford Health System, its director or agent to release information contained in the medical record of the patient identified above which includes information that may be stored in paper and/or electronic format. This includes records concerning general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; and demographic information. **Not for use for disclosure of psychotherapy notes.*

X 1. Name of **DOCTOR** or organization (and address) who will be reviewing these materials.

Name _____

Address _____

_____

Telephone _____

2. The purpose or need for such disclosure
___at the request of the patient___Personal Use___Continuation of Care___Attorney
___Workman's Compensation___Insurance___Disability___Other _____

3. Specific information to be disclosed/obtained as related to #2. **(indicate date of service):**
___ ER Memo _____ ___ Outpatient Visit _____
___ X-Ray/Lab _____ ___ Discharge Summary _____
___ Immunizations _____ ___ Diagnoses/Dates _____
X Other (be specific) Pathology materials

4. An authorization expires when the patient information is disclosed as permitted in the authorization or within the time specified in the authorization (which cannot exceed one year from the date of signature). This authorization is valid only if received by Henry Ford Health System within 90 days of the date signed. I may revoke this authorization anytime. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

5. HFHS does not condition treatment on whether this authorization is signed.

6. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

7. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copy information. This fee is waived when releasing information **directly** to a treating physician or health care facility.

X Signature: _____ Relationship (if other than patient): _____
Patient, Parent of Minor, Legal Guardian, Personal Representative*

X Date: _____

*If Legal Guardian or Personal Representative, a copy of appropriate documentation is necessary for release.