Patient Authorization to Release Medical Information

Patient Name (please print)	SS or Health Record Number	Patient DOB
_____	_____	_____/____/____

_____ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record
-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Emergency department record
- ☐ Operative report
- ☐ Most recent history and physical
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):

  _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):_____
- ☐ Consultation reports (please supply doctors' names):

  _____
- ☐ Other (please describe):

  _____

[NOTE: If this form is to be used in Michigan by a healthcare provider or facility for authorization by a patient or patient's authorized representative, the highlighted section below should be deleted and replaced with the following statement: "The identified information is being disclosed at the request of the patient or the patient's authorized representative."]

The identified information will be used for the following purpose:

☐ My personal records

☐ Sharing with other healthcare providers as needed

☐ Other (please describe):

_____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and /or treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure healthcare treatment. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____

_____

Address: _____

_____

This authorization will expire on (insert date or event):

_____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____/____/____

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ ____/____/_____

Witness Signature Date