LCS Job #

PATIENT INFORMATION RELEASE AUTHORIZATION

Request Copies of Medical Records from:

- ❑ HENRY FORD HOSPITAL & HEALTH NETWORK
- ❑ HENRY FORD BEHAVIORAL HEALTH SERVICES
- ❑ HENRY FORD MACOMB HOSPITALS
- ❑ HENRY FORD WEST BLOOMFIELD HOSPITAL
- ❑ HENRY FORD WYANDOTTE HOSPITAL
- ❑ HENRY FORD MAPLEGROVE CENTER
- ❑ HENRY FORD KINGSWOOD HOSPITAL

INSTRUCTIONS

Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

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

Date of Birth: _____ Last 4 Digits of SS #: _____ Sex: M / F Telephone:

Address: Street: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____
it's director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. However, 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); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers. Any alcohol and substance abuse information disclosed to you from records are protected by Federal confidentiality rules (42 CFPR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure ins expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR part 2. Fees for copies are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL333.26269.

Please check box below to include (if any) medical records for these services:

- ❑ Alcohol and Substance/Drug Abuse diagnosis and treatment
- ❑ Psychotherapy Notes

SPECIFIC INFORMATION TO BE REQUESTED/DISCLOSED

1. Name or title of person or organization and address to whom information is to be:

☑ Disclosed To: Legal Copy Services, Inc.

Address: 3280 N Evergreen Drive NE
Grand Rapids MI 49525

☑ Requested From: _____

Address: _____

2. Specific information to be disclosed/received. **Check box for service type and indicate date of service:**

- ☐ ER Memo _____
- ☐ X-Ray / Lab _____
- ☐ Immunizations _____
- ☐ Photographs _____
- ☐ Verbal Communication Only. Please specify if limited to: _____ _____
- ☐ Outpatient Visit _____
- ☐ Discharge Summary _____
- ☐ Diagnosis/Dates _____
- ☑ Other (specify)
- ☐ Inpatient Visit Dates: (*Important Documents such as Discharge Summary, History & Physical, Operative Reports, and Consultations*) _____ _____

3. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

4. I may revoke this authorization at any time. 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. Contact Referring Physician Office, One Ford Place, Detroit, Michigan 48202.

5. My care or treatment will not be conditioned on signing this authorization.

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 copying information. This fee is waived when releasing information **directly** to a treating physician or health care facility.

Signature _____ Relationship (if other than patient): _____

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

Date: _____

* If Legal Guardian, Personal Representative or person with authority under a durable medial power of attorney, a copy of appropriate documentation is necessary for release.