Authorization for Release of Patient Medical Information

Patient Name____________________ Birthdate____________ Last 4 digits of SSN __ __ __ __ Phone number__________
Address ____

I, ________________, herby authorize Correspondence from Mercy Memorial Hospital System or ________________________, it's Director or designee, or the Health Information Management Department to release information contained in my patient records, including alcohol and drug abuse records protected under the regulation in 42 Code of Federal Regulation, Part 2, if any, including communication made by me to a social worker, psychiatrist, psychologist and any information regarding communicable diseases and serious infections as defined by Michigan Department of Public Health rule which includes venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or organizations listed below, only under the conditions listed below.

RELEASE INFORMATION TO: ☐ Mercy Memorial Hospital System, ☐ Self, ☐ OR Specify below

____

If you would like Mercy Memorial Hospital System to release information to someone other than yourself or Mercy Memorial Hospital, please list the Physician, Organization, or Individual, and their Address

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SPECIFY WHAT INFORMATION IS TO BE RELEASED (i.e. results of test) Any and All is no longer acceptable under the privacy rule. You must be specific.

DATE OF HOSPITALIZATION OR TEST: ____

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SPECIFY WHAT INFORMATION IS TO BE EXCLUDED

I would prefer to have my medical records: ☐ Mailed to the address listed above OR ☐ Available for Pick up
SPECIFY HOW YOU WOULD LIKE TO RECEIVE THE COPIES OF YOUR MEDICAL RECORDS

You have the right to revoke this authorization at any time by submitting a written request to the Director of Health Information Management Department except to the extent that Mercy Memorial Hospital has already taken action on the authorization. If not previously revoked, this authorization will terminate upon, (specify event or date not to exceed sixty (60) days from the date of signature) (*Michigan Medical Record Access Act- Enrolled House Bill No. 4706)* ____________

Signature of: ☐ Patient ☐ Parent or Guardian ☐ Authorized Representative ☐ Designated Power or Attorney for Health
☐ Personal Representative of the Estate/Letters of Authority (Required if patient is deceased) (Please attach)

Information disclosed to a third party pursuant to this authorization may be subject to redisclosure and may no longer be protected by our policies and applicable law.

I attest that I am not prohibited from having access to these records or information by a protective order.

SIGNATURE: ________________________________ DATE:__________

Signature of Witness:______________________________ DATE:__________

CHARGE FOR RECORDS

- There is a $21.58 fee per request for a copy of the record. Patients may receive one copy of their record per year without charges.
- For paper copies
- $1.08 per page for the first 20pages
- $0.54 for pages 21-50
- $0.22 for pages 51 and over
- Please be advised that Michigan Law *MCL 333.26269* allows us to waive the charge for the following:
  - Patient Care

---------------------------**Attorneys and Subpoena Services**---------------------------

(Attorneys and Subpoena services must have this form notarized)

WHEN NECESSARY: ( )
Subscribed and sworn before me on this _____ day of __________, 20_____
Notary Public, County of ______________ State of ________________
My Commission expires: ______________ Name: ________________

---**For office use only**---

Patient photo identification verified☐ (if patient would like request mailed)
Date request will be available for pick up ________________

ROI