HARBOR OAKS HOSPITAL

35031 23 Mile Road, New Baltimore, MI 48047
Phone: 586-725-5777 Fax: 586-716-7524 (Medical Records)

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTHCARE INFORMATION

Fill in the appropriate information in each applicable section. Sign, date and retune the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____, **Date of Birth**: _____, SS# _____

I, _____ authorize the information specified below to be disclosed as follows:

From: Harbor Oaks Hospital

To: Name of Person _____

Organization: _____

Address _____

Phone: _____ FAX (if applicable) _____

By signing above I hereby authorize Harbor Oaks Hospital, or its 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 other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment (Check Each Item Requesting):

Discharge Summary	☐	Medication Regime	☐
Initial Psychiatric Evaluation	☐	Progress Notes	☐
Medical History & Physical	☐	Discharge Instructions	☐
Laboratory Reports (Excluding HIV)	☐	Other Specify	_____
\ Financial Information	☐	Full copy (charges may apply)	☐

If information in my records pertains to **HIV or Aids**, I expressly (**do**_____) (**do not** _____) authorize Harbor Oaks Hospital to disclose such information pursuant to this authorization. Check if not applicable (_____).

If information in my records pertains to drug and/or alcohol **abuse or dependence** I expressly (**do**___) (**do not**___) authorize Harbor Oaks Hospital to disclose such information pursuant to this authorization. Check if not applicable. (____)

I am requesting that information be disclosed for the purpose(s) of: (Please circle).

Continuation of Care Disability Personal Records Legal Other _____

This authorization is valid only if received within 60 days of being signed. This authorization will expire within 180 days of date requested or on _____ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
- I understand that Harbor oaks Hospital will not condition my treatment, payment, or enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and /or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Harbor Oaks Hospital and its affiliates and its representatives, from all legal liabilities that may result from the release of this information according to this request.

Signature: _____ *DATE SIGNED*_____

Patient, Parent of Minor, Legal Guardian, Personal Representative:

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R.§160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.