



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

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

### Instructions

Fill in the appropriate information in each applicable section. Sign, date and return 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 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):

	YES	NO		YES	NO
Discharge Summary	_____	_____	Medication Regime	_____	_____
Initial Psychiatric Evaluation	_____	_____	Progress Notes	_____	_____
Medical History & Physical	_____	_____	Discharge Instructions	_____	_____
Laboratory Reports (Excluding HIV)	_____	_____	Other Specify	_____	_____
Financial Information	_____	_____			

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 (\_\_\_\_\_).

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 at time of disclosure of requested information 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: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

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

DATE SIGNED \_\_\_\_\_

**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.