



MRN: _____

INSTRUCTIONS

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

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

Date of Birth: _____ SS#: _____ Sex: M/F Telephone: () _____

Address: Street: _____
City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____ Henry Ford Health System _____, 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; alcohol and drug abuse treatment; 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. **Not for use for disclosure of psychotherapy notes.*

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

Disclosed To: Legal Copy Services, Inc. Requested From: _____
PO Box 2845 _____
Grand Rapids, MI 49501 _____
Address Address

2. The purpose or need for such disclosure

___ At the request of the patient ___ Personal Use ___ Continuation of Care ___ Attorney
___ Workman's Compensation ___ Insurance ___ Disability X Other: Litigation

3. Specific information to be disclosed/obtained as related to #2. **Indicate date of service:**

___ ER Memo _____ Outpatient Visit _____
___ X-Ray /Lab _____ Discharge Summary _____
___ Immunizations _____ Diagnosis/Dates _____
X Other (specify) Any and all PHI from _____ until present.

4. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed. 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).

5. 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.

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

7. 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.

8. 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, Person under a POA* Date: _____

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