AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

COGNITIVE PATIENT LABEL

Questions: Contact Medical Records: 313.916.4540
Please mail completed form to: Medical Records 2799 W. Grand Blvd., Detroit, MI 48202 or to Medical Records email address: HFHSMedicalRecords@hfhs.org • fax number 313.916.3917
(Please keep in mind that emails sent over the internet may not be secure.)

Patient Information (please print)

Name (First, Middle, Last)		Maiden name or previous names	
Address	City	State	Zip Code
Date of Birth	Phone	E-mail Address if Applicable	

I authorize my records to be sent from:

Henry Ford Health System:

- ☐ HF Allegiance Health
- ☐ HF Allegiance Specialty Hospital
- ☐ HF Behavioral Health
- ☐ HF Hospital Detroit
- ☐ HF Kingswood Hospital
- ☐ HF Macomb Hospital
- ☐ HF Maplegrove Center
- ☐ HF West Bloomfield Hospital
- ☐ HF Wyandotte Hospital
- ☐ HF Other (Clinic/Medical Center): _____

Other Facility:

Name/Organization			
Address	City	State	Zip Code

I authorize my records to be released to:

Myself: (Select only one option)

- ❒ MyChart patient portal (patient request)
- ❒ E-mail to me at address above
- ❒ Mailed to me at address above
- ❒ On site inspection. (Authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.)
- ❒ Mailed to address below
- ❒ Faxed to number below
- ❒ Verbal communication about my care. Describe information to be shared: _____

  _____

Other: Disclose to - complete information below

Name/Organization			
Address	City	State	Zip Code
Phone Number	Fax Number		

Please complete below if you want to include medical records for these services:

☐ Substance Use Disorder diagnosis and treatment

Purpose: ☐ Continuation of Care ☐ Legal ☐ Personal ☐ Other _____

☐ Psychotherapy Notes

Specific Information Requested:

Type of Record requested	Date of Service	Type of Record Requested	Date of Service
☐ Discharge Summary		☐ Outpatient Record	
☐ Emergency Department		☐ Radiology Report	
☐ Laboratory Report		☐ Office Note	
☐ Immunizations		☐ Other:_____	
☐ Inpatient Record		_____	

By signing this authorization I hereby authorize Henry Ford Health System 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. 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), as applicable; communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable; demographic information; and treatment received by other health care providers. Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

I understand that:

- I may revoke (take back) 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 prior to receiving the revocation. Contact Henry Ford Health System Medical Records department. Contact information is available at the top of the form.
- This authorization expires when the patient information is disclosed as permitted in this authorization, or within one (1) year from the date that it is signed unless another expiration date is written here: _____ _____ (describe the date/event/condition upon which authorization will expire, which must be no longer than one year from the date signed)
- My care or treatment will not be conditioned on signing this authorization
- The person(s) to whom information is disclosed under this authorization may possibly redisclose 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.
- Henry Ford Health System and/or its copying service 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. (if legal guardian, Personal Presentative or person of authority under a durable medical power of attorney, a copy of appropriate documentation may be required)

Date_____ Time_____