IHA Office: _____ Authorization for Release of Information

I AUTHORIZE AND REQUEST (list who this request is addressed to here):

_____

PATIENT NAME:_____/_____/_____/_____

LAST FIRST MI MAIDEN OR OTHER NAME DATE OF BIRTH Last Four SS#

AUTHORIZED BY: (Patient, Parent or legal guardian); and I am authorized to make this disclosure:

Name: _____ **Date of Birth:** _____ **Last Four SS #:** _____**Phone#** _____

Address: _____**City**_____ **State**_____ **Zip Code:**_____

RELEASE TO:

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INFORMATION TO BE RELEASED:

- **Specifically any and all of the medical record information in your possession as well as any other employee, provider, nurse, nurse practitioner or any other person employed by IHA and involved in my health care;**
- Any records of medications, problem lists, tests, procedures or referrals ordered;
- Any records from any outside medical health providers, in-patient or out-patient that are part of my health record that are in the possession of IHA.
- **This authorization specifically includes my entire medical record including, Substance abuse, Mental Health, HIV related testing and treatments.**
- Other: _____

PURPOSE OF DISCLOSURE:

❑ Relocating out of area ❑ Changing doctor in area ❑ Specialist Consultation/second opinion ❑ Transfer from pediatric to adult doctor ❑Legal ❑ School
❑ Insurance Change (Non-par) ❑ Workers Compensation ❑ Doctor's Care ❑ Nursing Staff ❑ Other Staff ❑Other

1. I understand that this authorization will expire on _____ (Print the Date this form Expires) OR, 60 days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign.
4. I understand that in compliance with the State of Michigan laws pertaining to record copies, I may be charged a reasonable cost based fee no greater than $_____. There is no charge for medical records if copies are sent to facilities for Specialist care, school purposes, insurance billing, or for Workers' Compensation.

_____ _____ OR _____ _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____

RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

PRESENTED ID: _____ **VERIFIED BY:**_____**PROOF OF LEGAL GUARDIANSHIP:** _____

PROVICER REVIEWED: _____ **DATE** _____**DATE REQUEST FILLED:**_____ **BY:** _____

FEE COLLECTED: _____ **WRITTEN REQUEST TO REVOKE (ATTACH) PROC'D BY:**_____**EFF DATE:** _____