BOTSFORD
HEALTH CARE

Authorization for Release of Health Information

Please complete the sections below.

Section 1: Patient Information (please print):

Last Name	First Name	Middle Name
Date of Birth (MM/DD/YY)	Last four digits of Social Security Number or Medical Record Number:	☐ Male ☐ Female
Street Address		
City	State	Zip

Section 2: Who is making this request? Please check ONE box below.

☐ **I am the Patient.**

I am the Patient's Personal Representative because:

☐ I am the patient's custodial parent and I understand that I may need to provide evidence of my relationship.
☐ I am the patient's legal guardian and I have attached photocopies of all relevant documents.
☐ I am the patient's Durable Power of Attorney for Healthcare and I am providing documentation of the Power of Attorney and evidence that the patient is unable to make decisions for him or herself.

The Patient is deceased:

☐ I am the patient's Heir at Law including, but not limited to, his or her spouse. A Botsford Health Care (BHC) Personal Representative Statement is attached.
☐ I am the beneficiary of the patient's life insurance policy and I would like the medical record to be released to the life insurance company only.

Section 3: Specific Health Information to be released or disclosed:

What Health Information would you like to release?

☐ Complete Medical Record (not including genetic test results) for dates of service from: _____ to _____
☐ Abstract (An abstract is a summary of your care and will include your discharge summary and lab reports)
☐ Emergency Room Record
☐ Immunization Record
☐ Genetic Test Results - Genetic Test results will not be included unless specifically requested. Initial here _____
☐ Other (please describe) _____

Section 4: What action should be taken? Please select ONE.

☐ Provide a copy of my health information to me.
☐ Obtain copies of my health information. I have listed the names of the health care providers that I would like you to request my information from in Section 5.
☐ Let me look at my health information. I am not requesting a copy.
☐ Release my health information to someone else. I have listed where I would like my health information to be sent in Section 6.

Section 5: Complete this section if we are requesting medical records from another health care provider. We will request complete medical records. Where can we request those records from?

Name of Health Care Provider		
Street Address		
City	State	Zip

Section 6: Complete this section if you are requesting copies of your Health Information. Where would you like to receive your Health Information?

- ☐ I will pick up My Health Information from the department where I requested the information or I would like to have it emailed to me.
- ☐ Please mail it to me at the address listed in Section 1.
- ☐ Please mail it to the address below.

Name		
Street Address		
City	State	Zip
Phone Number	Fax Number (if the records are to be faxed)	

Section 7: What format would you like this in?

- ☐ Paper copy
- ☐ Electronic pdf format on a CD or DVD (for Radiology services only)
- ☐ On an unencrypted flash drive in pdf format
- ☐ Sent in a pdf format unencrypted to this email address: _____

Important!
Health Information sent in an unencrypted email is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted email, you are acknowledging and accepting these risks.

Section 8: Signature of Patient or Patient Representative

By signing this Authorization, I hereby request and authorize that BHC and its agents and employees, or other health care provider, release the following Protected Health Information or to request medical records from another facility or health care provider. I understand the following:

- My Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- My Health Information may include information about behavioral or mental health services, treatment for alcohol and drug abuse.
- This Authorization is voluntary. My treatment will not be impacted even if I do not sign this Authorization.
- This Authorization is valid for 90 days from the date that I signed unless another date is listed below.
- I may revoke or withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal or state privacy laws, and could be re-disclosed by the person(s) receiving it.
- If I am not making this request in person, I may be asked to provide a copy of my current driver's license.
- There may be a fee associated with my request.

Signature	**Date**
Authorization valid for 90 days from the date signed unless another date is provided here:	

*** If mailing this request, please include a copy of your current driver's license.**