Oakwood

Health Information Management Department

ROIAUTH

HEALTH INFORMATION RELEASE AUTHORIZATION

991992 Effective: 09/05 Rev: 05/14 01/15

I, _____ _____
(Print Patient's Name) (Telephone Number)

_____
(Address)

authorize _____
(Name of Facility releasing medical information)

_____
(Address)

to release information contained in my patient records, including, as applicable: information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Community Health (MDCH) (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndrome "AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulations, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. Name and address of receiver of information:

_____

_____

2. Specific type of information to be disclosed, (include date(s) of service):

_____

_____

3. Provide your e-mail address if you want your information released electronically: _____

_____

4. The purpose and need for such disclosure:

_____

_____

5. I understand that I have a right to revoke this authorization at any time except as noted below. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the appropriate department/facility that was authorized to release information. I understand that the revocation will not apply to information that has already been released in response to this authorization or where the OHI facility has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The right to revoke is also discussed in the OHI Privacy Notice.

   Unless otherwise revoked, this authorization will expire upon the occurrence of the following event:

   ☐ Upon completion of request ☐ Other: _____

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, however, my request to release information will not be fulfilled. I understand that I may inspect or copy the information to be used or disclosed. I understand that Oakwood will not refuse to treat me if I do not sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal and state confidentiality rules.

I represent that I am the patient or an Authorized Representative of the patient as that term is defined in Michigan law regarding the release of medical records.

_____ _____ _____
Signature of Patient or Authorized Representative Date Time

_____ _____
If signed by Authorized Representative, relationship to patient Signature of Witness

_____ Last 4 digits of Patient's Social Security Number → ☐ ☐ ☐ ☐
Patient's Date of Birth

Acknowledgement of Receipt of Record by: _____ _____ _____
Print Name *Signature* *Date/Time*