Grace Health
181 West Emmett Street
Battle Creek MI, 49037
Telephone Number: 269-965-8866 / Fax Number: 269-966-2627 / Email: hidnoreply@gracehealthmi.org

# Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: ____/____/____

Previous Name(s): _____ Phone Number: (____) _____

Address: _____
Street City State Zip

**I authorize Grace Health to:**
*(Check only one option)*

❑ Send information *TO* ❑ Obtain information *FROM* ❑ Personal Use/Self

Name of Facility / Provider / Person: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ Fax Number: (____) _____

Facility email address: _____

**Specific information to be released – From Date:** _____ **To Date:** _____

I request the following information to be released, which may include but is not limited to history, testing, diagnosis, and/or treatment of drug or alcohol abuse, mental health (such as psychotherapy and behavioral health), communicable diseases and infections (such as venereal disease, Tuberculosis, Hepatitis A, B, C, HIV, HIV testing), Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC). **I understand that if I do not designate a specific date range, I (or designated recipient) will receive only the last 24 months of records requested.**

❑ All records in designated record set per Grace Health policy (see reverse)

Or select from the following:

❑ Lab Results ❑ Medical Visits ❑ Immunizations ❑ Dental Records ❑ Mental Health ❑ OB/GYN ❑ Specialty Visits
❑ Dental X-Rays ❑ Substance Use Disorder (SUD) / Medication Assisted Treatment (MAT)
❑ Other (Specify) _____

**Purpose for release:**

❑ Transferring care to another provider ❑ Other: _____

I give Grace Health the authorization to verbally exchange information with the named facility/person listed above regarding the information being released. I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request. **This release is effective for one year from the date of execution.** However, it may be revoked by me at any time by providing written notice to the above-named party; I understand information may have been released when authorization was valid. I authorize Grace Health to use and disclose any records protected by 42 CFR Part 2 for treatment, payment, and operations (TPO). Substance Use Disorder (SUD) release authorization is ongoing until revoked by written notice. A facsimile or photocopy of this document will be accepted in lieu of the original. I consent to receive all records and communications electronically.

_____ _____ _____
(Signature) (Printed Name) Date

❑ Patient/Legal Representative ❑ Parent ❑ Guardian

_____ _____
Witness (Printed Name) Date

***For Health Information Use Only:***

| HID Received: | Processed By: | Method: ❑ Faxed ❑ Mailed ❑ Emailed ❑ Given to patient / legal representative ❑ Patient Portal ❑ USB |
|---|---|---|
| Date Processed: | | |

(over)

## Grace Health's Designated Record Set

Photocopy of release request

Progress notes *(24-months)*

Test results of labs *(24-months)*

Immunization records *(pediatric patients only)*

Medication/allergy list

Growth charts, birth-5 years of age *(pediatric patients only)*

Office visit notes *(including PCP and any specialties as applicable)*

Radiology

Diagnostic testing

Consults *(24-months)*

Procedures

OB Records *(current pregnancy only)*

Sensitive information, if authorized *(24-months)*

*Note: Information will be provided 24 months in the past from signature on Authorization for Release of Medical Information.*