



- CHM     HWH
- DRH     KEI
- DSH     RIM
- HUH     SGH
- HVSH     \_\_\_\_\_

321

Patient Label

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION (NOT FOR PSYCHOTHERAPY NOTES)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Maiden / Other Name \_\_\_\_\_

Patient Address \_\_\_\_\_  
Street City State Zip

Phone Number \_\_\_\_\_

I authorize \_\_\_\_\_

Healthcare facility / physician  
to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services)

Name to whom information may be released: \_\_\_\_\_

Address \_\_\_\_\_ City State Zip Code

Area Code Telephone Number Fax Number

Date(s) of Treatment: \_\_\_\_\_

**Specific Type of Information to be Disclosed**

- Discharge Summary     X-Ray Reports     ED Reports
- History & Physical     X-Ray Images / CD
- Consultations     Operative Reports
- Laboratory Results     Pathology Reports     Other(specify): \_\_\_\_\_

**Method of Disclosure**

- Paper
- CD / DVD format, where available
- Other(specify): \_\_\_\_\_

The Purpose and Need for Such Disclosure: \_\_\_\_\_

*For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.*

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

\_\_\_\_\_  
Signature of Patient / Parent / Personal Representative \_\_\_\_\_ / \_\_\_/\_\_\_/\_\_\_  
Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_



## **COPYING OF MEDICAL RECORDS**

The Detroit Medical Center (DMC) has contracted with HealthPort to process your request for medical records. The State of Michigan has become a regulated state for the pricing of copying medical records and the following rates went to effect

February 19, 2015

**COPIES FOR PATIENTS.** There will be a charge to patients for medical record requests. The charge for this service will be:

\$1 .18 per page for pages 1-20  
\$ .59 per page for pages 21-50  
\$ .24 per page for pages 51 +

**Plus shipping and handling**



120 Bluegrass Valley Parkway Alpharetta, GA 30005

If you have any questions please direct your calls to HealthPort  
Customer Service Department at 1-800-367-1500

I acknowledge that I will receive a statement directly from HealthPort.

By signing this agreement, I hereby acknowledge, I will be responsible for any charges for reproduction of my medical records.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_