AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

Patient Label

Request Information from (check all that apply):

- ❑ HENRY FORD ALLEGIANCE HEALTH
- ❑ HENRY FORD ALLEGIANCE SPECIALTY HOSPITAL
- ❑ HENRY FORD BEHAVIORAL HEALTH SERVICES
- ❑ HENRY FORD HOSPITAL DETROIT
- ❑ HENRY FORD KINGSWOOD HOSPITAL
- ❑ HENRY FORD MACOMB HOSPITAL
- ❑ HENRY FORD MAPLEGROVE CENTER
- ❑ HENRY FORD WEST BLOOMFIELD HOSPITAL
- ❑ HENRY FORD WYANDOTTE HOSPITAL
- ❑ HENRY FORD OTHER (CLINIC/MEDICAL CENTER) _____

1. Patient Information

Name (First, Middle, Last)	(Maiden or any previous last names)		
Current Address	City	State	Zip Code
Date of Birth	Phone Number		

I, _____hereby authorize_____
its director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on general medical care; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received by other health care providers. Any alcohol and substance use information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR part 2). These Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL333.26269.

Please check box(s) below if you want to include medical records for these services:

- ❑ Alcohol and Substance/Drug Use diagnosis and treatment.
- ❑ Psychotherapy Notes.

2. Release (disclose) Information to:

Name of Recipient			Phone Number
Legal-Ease Digital Imaging			855-534-4003
Address			Fax Number
P.O. Box 1017			
City	State	Zip Code	
Flint	MI	48501-1017	

Requesting information from:

Name of Recipient			Phone Number
Address			Fax Number
City	State	Zip Code	

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Check box(s) below for service type, description and date of service:

	Description and	date of service
	Discharge Summary	
	Emergency Dept. Record	
	Laboratory Report	
	Hospice	
	Immunizations	
	Inpatient Record	
	Office Note	

	Description and	date of service
	Outpatient Record	
	Radiology Report	
	Clinical Photographs	
	Clinical Video	
	Films/CDs:_____	
	Other:_____	

❑ Obtain a copy of my medical record (Specific information to be released is indicated above).

❑ Access and Inspect my medical record.
If requesting a copy of or access and inspection of your medical record, this authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.

❑ Verbal Communications about my care.

Please describe the information that can be shared. _____.

❑ **This box may only be checked by the patient after consult with their provider:** I authorize the release of the information indicated above to be released to the Henry Ford provider indicated in Section 2 of this form for professional/educational use on the provider's professional social media sites (e.g. Facebook, Twitter, Instagram, YouTube, LinkedIn, Doximity etc.). Signing this section does not affect my medical care. I understand that my likeness, name, Medical Record Number and birthdate will be removed before the information is made public on social media. If I change my mind afterward, however, neither my provider nor HFHS can undo the use of my information that has already been shared by my provider and made public in a social media post. Once the social media post is made public, it's possible that others may repost the information on social media and the internet. I will not be paid by my Henry Ford provider for use of my information for this purpose.

3. This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____. (Date cannot exceed one year from the date of signature below).

4. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization. Contact Medical Records, 2799 W. Grand Blvd., Detroit, Michigan 48202.

5. My care or treatment will not be conditioned on signing this authorization.

6. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

7. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature _____ Relationship (if other than patient): _____

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

Date: _____ Time: _____

* If Legal Guardian, Personal Representative or person with authority under a durable medial power of attorney, a copy of appropriate documentation