Request/Authorization for Disclosure of Protected Health Information

Patient G#: _____
Patient C#: _____
ID checked by: _____

Patient Identification	Name: _____ Birthdate: _____ Address: _____ Phone: _____ City/State/Zip: _____ Maiden/Prior Name: SSN: ***-**-	
Provider who has Your Medical Information	Provider/Facility: _____ Address: _____ City/State/Zip: _____ Phone: Fax:	
Disclose Information to:	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: Fax:	
Mammography Films	☐ **I give my permission for Grand River Hospital District to obtain my prior mammography films and results, and to obtain any subsequent test results, including but not exclusive to, ultrasound or biopsy results.**	
Information to be Released:	☐ History & Physical	☐ Emergency Room Visit
	☐ Discharge Summary	☐ Clinic Visit(s)
	☐ Operative/Procedure Report	☐ Radiology reports; CT MRI US X-Ray
	☐ Pathology Report	☐ Radiology Films: List
	☐ Lab Reports	☐ Other
	☐ Therapy (PT/OT)	☐ Billing
Limit Records to:	Time period from: _____ to _____ Concerning specific diagnosis or treatment of:	
Purpose of Disclosure:	☐ At the request of the patient ☐ Legal ☐ Insurance Claim ☐ Other ☐ Transfer of records to new physician or consult- continuity of care	
Expiration DATE:	This authorization will expire one year from the date of signature or on:	
Revocation	I understand that I may revoke this authorization at any time by sending written notice to the health care facility/provider noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.	
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To" I understand that the information to be released may include information regarding treatment of mental health, alcohol and drug usage, and HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. Signature of Patient or Representative _____ Date: _____ * *If signed by representative, please state authority to act on behalf of the patient.	
	I understand I am not required to sign this authorization if I do not wish to release my records	

A photocopy/fax of this authorization will be treated in the same manner as an original

** **Grand River Health - HIM/Medical Records Department: Fax # 970-625-2752 Phone # 970-625-6412** **

Comments: _____

_____ Initial: _____