



Authorization
RELEASE OF
MEDICAL INFORMATION

The Corewell Health MyChart app
is also available for viewing or
requesting your medical records.

Patient name Date of birth Previous name
Phone Last 4 digits of Social Security number (optional)
Address
City State Zip

I AUTHORIZE MY RECORDS TO BE SENT FROM:

Corewell Health West Hospitals:

- Butterworth Hospital, Helen Devos Children's Hospital, Meijer Heart Center, Lemmen-Holton Cancer, Surgical Centers (East Paris, Lake Drive, South Pavilion)
Blodgett Hospital Big Rapids Hospital Gerber Hospital Greenville Hospital
Ludington Hospital Pennock Hospital Reed City Hospital Zeeland Hospital

Corewell Health Southeast Hospitals:

- Royal Oak Hospital Dearborn Hospital Farmington Hills Hospital
Taylor Hospital Trenton Hospital Grosse Pointe Hospital
Troy Hospital Wayne Hospital

Corewell Health Southwest Hospitals:

- Lakeland Hospital - St. Joseph Watervliet Hospital
Lakeland Hospital - Niles

Corewell Health Medical Office:

- Specify office or doctor

Other Organization: Name Fax
Address City State Zip code

I AUTHORIZE MY RECORDS TO BE RELEASED TO: (Check only one)

- Mailed to address (listed above) as: Paper
A compact disc (CD) (may not be available at all locations)
MyChart Patient Portal Email
Other: Name/Organization
Address
City State Zip
Phone Fax

INFORMATION REQUESTED:

From this/these date(s) of service

Information:

- Summary (Doctor's report and test results) History and Physical Pathology report
Consult Procedure report Radiology report (see below for images)
Discharge summary Office visit Records related to specific problem of
Emergency Department Immunization record Bill, type: UB04 1500 Detail bill
Lab report

Radiology images only: Select images along with specific dates of service to be released. Images can be sent by secure email (via Ambra). Provide email (above).

- X-ray MRI CT scan Nuclear Medicine
Ultrasound Mammography PET/CT scan Interventional Radiology

Dates: Dates: Dates: Dates:



Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE OVER ->



**PURPOSE OF DISCLOSURE:**

NOTE: Required for records being released to anyone other than the patient.

- Patient request     Attorney/Legal     Insurance     Continued Patient Care
- Other (specify) \_\_\_\_\_

**If you DO NOT WANT to release any of your specially protected information in the categories below, check the box(es) for that category:**

- Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules, which include venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), HIV test, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and \_\_\_\_\_ (specify other if known).
- Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.
- Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.
- The release of my DNA test result regarding a diagnosis of \_\_\_\_\_ (Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that Corewell Health assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Corewell Health provider.

There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974, as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

This authorization may be revoked in writing at any time as outlined in the Corewell Health Joint Notice of Privacy Practices. Corewell Health does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits.

This authorization is valid for one (1) year from the date of my signature, unless I specify another date \_\_\_\_\_

**TIME** \_\_\_\_\_ **DATE** \_\_\_\_\_ Patient or Legal Representative signature \_\_\_\_\_  
Basis of legal authority to act for patient \_\_\_\_\_

**TIME** \_\_\_\_\_ **DATE** \_\_\_\_\_ \_\_\_\_\_  
Witness

**TIME** \_\_\_\_\_ **DATE** \_\_\_\_\_ \_\_\_\_\_  
Second Witness (required if patient is unable to sign or gives verbal permission)

**OFFICE USE ONLY**

Identification (ID) checked?  Yes  No    Driver's license number \_\_\_\_\_

Copies sent:  To MyChart     Mailed     Faxed     Emailed     Picked up

Medical record number \_\_\_\_\_

Completed by \_\_\_\_\_ (print staff name)

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