Grace Health

Authorization for Release of Medical Information

_____ _____
Patient Name Date of Birth

I Authorize the Release of Medical Information

❑ From ❑ To **❑ From ❑ To**

Grace Health
181 West Emmett Street
Battle Creek, MI 49037-2963
Telephone (269) 965-8866
Fax (269) 966-2627

Specific information to be disclosed:

❑ Progress Notes ❑ Test Results ❑ Childhood Immunizations

❑ _____

Please initial appropriate boxes:

This release also specifically allows the release of the following sensitive information. If you **DO NOT** wish to have any or part of the information released, please **INITIAL** inside the appropriate box:

☐ Any record of treatment for drug and/or alcohol dependency or abuse;

☐ Any record of mental health treatment;

☐ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or AIDS.

Purpose for release: ❑ Transferring care to another provider

❑ At the request of the patient/legal representative

❑ _____

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. A facsimile or photocopy of this document will be accepted in lieu of the original.

_____ _____
Patient/Legal Representative ❑ Parent ❑ Guardian ❑ _____ Date

_____ _____
Witness Date