

Grace Health

181 West Emmett Street
Battle Creek MI, 49037

Telephone Number: 269-965-8866 / Fax Number: 269-966-2627

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: ____/____/____

Previous Name(s): _____ Phone Number: (____) _____

Address: _____
Street City State Zip

I authorize Grace Health to:

Send information To Obtain information FROM Exchange verbal information with

Name of Facility / provider / Person: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ Fax Number: (____) _____

Specific information to be released – From Date: _____ **To Date:** _____

I request the following information to be released, which may include alcohol and drug dependency or abuse, mental health treatment, and / or testing, care, treatment, reporting, or research pertaining to infection with HIV or AIDS.

- Lab Results Radiology Reports Prenatal Behavioral Health Medical Visits
- Dental Gynecology Immunizations Medication List Forms(s)
- Other (Specify) _____

Purpose for release:

- Transferring care to another provider Other: _____
- At the request of the patient/legal representative Coordination of care

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 _____

For Office Use Only:

HID Received:	Processed By:	Method: <input type="checkbox"/> Faxed <input type="checkbox"/> Mailed <input type="checkbox"/> CCDA <input type="checkbox"/> Given to patient / legal representative <input type="checkbox"/> Other: _____
Date Processed:		
Date Returned:	Reason for Return:	
Prior Records / Category Location(s):		