Grace Health
181 West Emmett Street
Battle Creek MI, 49037
Telephone Number: 269-965-8866 / Fax Number: 269-966-2627 / Email: hidnoreply@gracehealthmi.org

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: (____)_____

Facility email address: _____

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: _____

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. I consent to receive all records and communications electronically.

_____ _____
❑ Patient/Legal Representative ❑ Parent ❑ Guardian (printed name) Date

_____ _____
Witness (printed name) Date

For Office Use Only:

HID Received:	Processed By:	Method: ❑ Faxed ❑ Mailed ❑ Emailed ❑ CCDA ❑ Given to patient / legal representative ❑ Other:_____
Date Processed:	Date Returned:	
Prior Records / Category Location(s):		