## 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**

Address: Street City State Zip  I authorize Grace Health to:						
Street   City   State   Zip	Patient Name:			Date of Birth:	/	
I authorize Grace Health to:  ☐ Send information TO ☐ Obtain information FROM ☐ Exchange verbal information were provided by the scaling of	Previous Name(s):			Phone Number: ()		
I authorize Grace Health to:  ☐ Send information TO ☐ Obtain information FROM ☐ Exchange verbal information were provided by the scaling of	Address:	Street	City		State	Zip
Send information TO						
Name of Facility / Provider / Person:    Address:	I authorize Grace Health to:					
Address:    Street   City   State   Zip	☐ Send information <i>TO</i>	☐ Obtain information FROM	☐ Exchange verbal information with			
Phone Number: (	Name of Facility / Provider / Person:					
Phone Number: (	Address:		211			
Specific information to be released – From Date:			,			·
Specific information to be released – From Date:  I request the following information to be released, which may include but is not limited to history, testing, diagnosis, and/or treatmed drug or alcohol abuse, mental health, communicable diseases and infections (such as venereal disease, Tuberculosis, Hepatitis C, HIV, HIV testing), Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC). I understand that if I designate a specific date range, I (or designated recipient) will receive only the last 24 months of records requested.  Lab Results  Medical Visits  Medical Visits  Dob/GYN  Specialty Visits  Purpose for release:  Transferring care to another provider  I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal provider. 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 treatment an						
I request the following information to be released, which may include but is not limited to history, testing, diagnosis, and/or treatmed drug or alcohol abuse, mental health, communicable diseases and infections (such as venereal disease, Tuberculosis, Hepatitis C, HIV, HIV testing), Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC). I understand that if I designate a specific date range, I (or designated recipient) will receive only the last 24 months of records requested.  Lab Results  Medical Visits  Immunizations  Other (Specify)  Purpose for release:  Transferring care to another provider  I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal provides. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may						
□ Behavioral Health □ OB/GYN □ Specialty Visits □ Other (Specify) □ Other: □ Other: □ Other: □ Understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal product. □ Understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain treatment a	I request the following information to be reldrug or alcohol abuse, mental health, come C, HIV, HIV testing), Acquired Immunodef	eased, which may include but is r municable diseases and infection ficiency Syndrome (AIDS) and Al	not limited to his is (such as vene IDS related com	tory, testing, c ereal disease, nplex (ARC).	diagnosis, and Tuberculosis, I understand	or treatment of Hepatitis A, B,
□ Other (Specify)  Purpose for release: □ Transferring care to another provider □ Other: □ Understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal provider. 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	☐ Lab Results	□ Medical Visits □ Imr			nunizations	
Purpose for release: ☐ Transferring care to another provider ☐ Other: ☐ Understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal provider. ☐ Understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain	☐ Behavioral Health	□ OB/GYN		☐ Spe	cialty Visits	
☐ Transferring care to another provider ☐ Other:	☐ Other (Specify)					
I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal pr 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	Purpose for release:					
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 obt						
at any time by providing written notice to the above-named party. A facsimile or photocopy of this document will be accepted in li the original. I consent to receive all records and communications electronically.	rules. I understand this is an optional forr photocopy of this form on request. This rel at any time by providing written notice to the	m and my refusal to sign it will no lease is effective for one year from ne above-named party. A facsimil	ot affect my abing the date of explored or photocopy	lity to obtain t ecution; howe	treatment and ever, it may be	I may obtain a revoked by me
□ Patient/Legal Representative □ Parent □ Guardian (printed name) Date	☐ Patient/Legal Representative ☐ Par	rent Guardian (printed name)				Date
Witness (printed name)  Date		ness (printed name)				Date
For Office Use Only: HID Received: Processed By: Method:		Processed By:	Method:			
□ Faxed □ Mailed			☐ Faxed ☐ Mailed			
Date Processed:  Date Returned:  Given to patient / legal representative  Other:		Date Returned:	☐ CCDA☐ Given to patie	ent / legal repres	sentative	
Prior Records / Category Location(s):	Prior Records / Category Location(s):					