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 but is not limited to history, testing, diagnosis, and/or treatment of drug or alcohol abuse, mental health, communicable diseases and infections (such as venereal disease, Tuberculosis, Hepatitis A, B, C, HIV, HIV testing), Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC). I understand that if I do not designate a specific date range, I (or designated recipient) will receive only the last 24 months of records requested.

❑ Lab Results ❑ Medical Visits ❑ Immunizations
❑ Behavioral Health ❑ OB/GYN ❑ Specialty Visits
❑ 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):		