Corewell Health™

Authorization RELEASE OF MEDICAL INFORMATION

The Corewell Health MyChart app is also available for viewing or requesting your medical records.

Patient name _____ Date of birth __/__/____ Previous name _____

Phone (____) _____ Last 4 digits of Social Security number _____ (optional)

Address _____

City _____ State _____ Zip _____

I AUTHORIZE MY RECORDS TO BE SENT FROM:

Corewell Health West Hospitals:

☐ Butterworth Hospital, Helen Devos Children's Hospital, Meijer Heart Center, Lemmen-Holton Cancer, Surgical Centers (East Paris, Lake Drive, South Pavilion)

☐ Blodgett Hospital ☐ Big Rapids Hospital ☐ Gerber Hospital ☐ Greenville Hospital

☐ Ludington Hospital ☐ Pennock Hospital ☐ Reed City Hospital ☐ Zeeland Hospital

☐ _____

Corewell Health Southeast Hospitals:

☐ Royal Oak Hospital ☐ Dearborn Hospital ☐ Farmington Hills Hospital

☐ Taylor Hospital ☐ Trenton Hospital ☐ Grosse Pointe Hospital

☐ Troy Hospital ☐ Wayne Hospital ☐ _____

Corewell Health Southwest Hospitals:

☐ Lakeland Hospital - St. Joseph ☐ Watervliet Hospital

☐ Lakeland Hospital - Niles ☐ _____

Corewell Health Medical Office:

☐ Specify office or doctor _____

Other Organization: Name _____ Fax (____)_____

Address _____ City _____ State ____ Zip code _____

I AUTHORIZE MY RECORDS TO BE RELEASED TO: *(Check only one)*

☐ Mailed to address (listed above) as: ☐ Paper

☐ A compact disc (CD) (may not be available at all locations)

☐ MyChart Patient Portal ☐ Email _____

☐ Other: Name/Organization _____

Address _____

City _____ State ____ Zip _____

Phone (____) _____ Fax (____) _____

INFORMATION REQUESTED:

From this/these date(s) of service _____

Information:

☐ Summary (Doctor's report and test results) ☐ History and Physical ☐ Pathology report

☐ Consult ☐ Procedure report ☐ Radiology report (see below for images)

☐ Discharge summary ☐ Office visit ☐ Records related to specific problem of _____

☐ Emergency Department ☐ EEG/ECG/EMG

☐ Immunization record ☐ Bill, type: ☐ UB04 ☐ 1500 ☐ Detail bill

☐ Lab report ☐ _____

Radiology images only: ***Select images along with specific dates of service to be released. Images can be sent by secure email (via Ambra). Provide email (above).***

☐ X-ray ☐ MRI ☐ CT scan ☐ Nuclear Medicine

☐ Ultrasound ☐ Mammography ☐ PET/CT scan ☐ Interventional Radiology

Dates:	**Dates:**	**Dates:**	**Dates:**
_____	_____	_____	_____
_____	_____	_____	_____

OVER →

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

* X 0 1 7 4 3 *

PURPOSE OF DISCLOSURE:

NOTE: Required for records being released to anyone other than the patient.

☐ Patient request ☐ Attorney/Legal ☐ Insurance ☐ Continued Patient Care

☐ Other (specify) _____

If you *DO NOT WANT* to release any of your specially protected information in the categories below, check the box(es) for that category:

☐ Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules, which include venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), HIV test, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and _____ (specify other if known).

☐ Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.

☐ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

☐ The release of my DNA test result regarding a diagnosis of _____ (Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that Corewell Health assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Corewell Health provider.

There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974, as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

This authorization may be revoked in writing at any time as outlined in the Corewell Health Joint Notice of Privacy Practices. Corewell Health does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits.

This authorization is valid for one (1) year from the date of my signature, unless I specify another date _____

TIME _____ **DATE** _____ Patient or Legal Representative signature _____

Basis of legal authority to act for patient _____

TIME _____ **DATE** _____ _____

Witness

TIME _____ **DATE** _____ _____

Second Witness *(required if patient is unable to sign or gives verbal permission)*

OFFICE USE ONLY

Identification (ID) checked? ☐ Yes ☐ No Driver's license number _____

Copies sent: ☐ To MyChart ☐ Mailed ☐ Faxed ☐ Emailed ☐ Picked up

Medical record number _____

Completed by _____ (print staff name)

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

