Spectrum Health

Authorization RELEASE OF MEDICAL INFORMATION

MEDICAL RECORD NUMBER _____

Patient name _____ Date of birth _____

Maiden name _____

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

Address _____

City _____ State _____ Zip _____

RECORD RELEASE

I authorize my records to be sent FROM:

- ☐ All Spectrum Health entities
- ☐ Butterworth Hospital: Includes Helen DeVos Children's Hospital, Meijer Center, Grand Rapids Surgical Centers (East Paris, Lake Drive, South Pavilion)
- ☐ Big Rapids Hospital
- ☐ Blodgett Hospital
- ☐ Gerber Memorial Hospital
- ☐ Kelsey Hospital
- ☐ Ludington Hospital
- ☐ Pennock Hospital
- ☐ Reed City Hospital
- ☐ United Hospital
- ☐ Zeeland Hospital
- ☐ Spectrum Health Medical Group/ Hospital Group: Specify office or doctor _____
- ☐ _____

I authorize my records to be released TO: *(Select One)*

- ☐ Mailed to address listed above as a: ☐ Paper form ☐ Compact disc (CD)
- ☐ MyChart Patient Portal
- ☐ Other _____
- ☐ Mailed to other: Name/Organization _____
  Address _____
  City _____ State _____ Zip _____
  Phone _____ Fax _____

INFORMATION REQUESTED

From this/these date(s) of service:

_____

Information:

- ☐ Abstract record
- ☐ Billings/invoices/ statements
- ☐ Consults
- ☐ Discharge summary
- ☐ EEG/ECG/EMG
- ☐ Emergency record
- ☐ History and Physical
- ☐ Immunization record
- ☐ Inspection only
- ☐ Lab reports
- ☐ Office visits
- ☐ Pathology reports
- ☐ Pathology slides
- ☐ Procedure reports
- ☐ Psychotherapy notes
- ☐ Radiology reports (see below for images)
- ☐ Records related to specific problem of _____
- ☐ _____

Radiology images only: ***Select images along with specific dates of service to be released.***

☐ X-ray	☐ MRI	☐ CT scan	☐ Nuclear Medicine
☐ Ultrasound	☐ Mammography	☐ PET/CT scan	☐ Interventional Radiology
Dates:	**Dates:**	**Dates:**	**Dates:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OVER →

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.

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

X01743 (11/20) – Front - (Spanish X13399) (Vietnamese X19128)

* 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 Spectrum Health assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Spectrum Health provider.

There is potential that information disclosed under the 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 Spectrum Health Joint Notice of Privacy Practices. Spectrum Health does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits.

This authorization will expire sixty (60) days from the date of my signature, unless I specify otherwise

_____

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 ☐ Picked up

HIM to mail? ☐ Yes ☐ No Completed by _____ (print staff name)

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
[81 FR 31465, May 16, 2016; 81 FR 46613, July 18, 2016]

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.359.1607 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.844.359.1607. (رقم هاتف الصم والبكم: 711).

