Ascension Providence Rochester Hospital

1101 W. University Drive
Rochester, MI 48307
248-652-5000

Patient name:_____

Address:_____

City:_____State:____Zip Code:_____

Date of Birth:_____ HIM #: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   ❑ Ascension Providence Rochester Hospital, 1101 W. University Drive, Rochester, MI 48307-1831
   ❑ Other: _____
3. The records may be released to: Name:_____
   Address:_____
4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

❑ Entire record	❑ Anesthesia report(s)	❑ EEG/EKG	❑ Standard Release
❑ Cardiology report(s)	❑ Stress test	❑ Medication list	❑ ED Report
❑ Pathology report(s)	❑ ECHO	❑ List of allergies	❑ Speech Therapy
❑ Operative report	❑ Immunization record	❑ Discharge summary	❑ Physical Therapy
❑ History and Physical	❑ Consultation report(s)	❑ Laboratory reports(s)	❑ Billing Information
❑ Family Care Center Record	❑ Prostate Center Record		

   ❑ X-ray and imaging, ____films released_____
   ❑ Records related to a specific problem of_____
5. Purpose of Disclosure:
   ❑ Continuing Medical Care ❑ Attorney/Litigation ❑ Insurance/Reimbursement Purposes
   ❑ Self/Personal Records ❑ Justification of disability ❑ Previous Medical History
6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information quired about behavioral or mental health services, and treatment for alcohol and drug abuse. Code 42 of Regulations, Part 2.
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
   If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.
8. I understand and acknowledge that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the pontential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 248-652-5221.

I would like a copy of this consent: ❑ Yes ❑ No Copies are to be: ❑ Mailed ❑ Picked Up

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Office Use:

Record Released to:_____ _____
Date

Date:_____ Time:_____ Record Released by:_____

ID Checked: ❑ Yes ❑ No

(REV. 8/18)

50420