Authorization for the Release of Health Care Information

☐ **Ascension Borgess Hospital**
1521 Gull Road
Kalamazoo, MI 49048

☐ **Ascension Borgess-Pipp Hospital**
411 Naomi Street
Plainwell, MI 49080

☐ **Ascension Borgess-Lee Hospital**
420 West High Street
Dowagiac, MI 49047

I authorize:_____
to release the following health care information regarding:

Patient's Name:_____

Date of Birth: _____

Patient's current home address _____

City, State, ZIP_____ Phone: (_____)_____

1. Records relating to visit(s)/service(s) of: _____

2. Information to be released:

☐ History & Physical
☐ Operative Report
☐ Emergency Room Report
☐ X-ray Films and/or Radiology Reports
☐ Clinical Resume/Discharge Summary
☐ Consultation(s)
☐ Laboratory Report(s)
☐ Entire Record
☐ Other _____

The following information may be included in the records you are requesting to be disclosed and/or released. If **one or more** of the following apply, and you **do not** wish to have the information released, you must place your initials on the appropriate line(s):

____ Treatment of emotional illness, including documentation by any psychologist or psychiatrist (this **does not** include psychotherapy notes)
____ Treatment of alcohol or substance abuse
____ Documentation by Social Service personnel
____ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex
____ Treatment of venereal disease, tuberculosis or communicable disease as specified by the Michigan Dept. of Community Health

Information is to be released to the attention of: _____
_____
_____
_____

PLEASE RETURN THIS FORM WITH THE REQUESTED RECORDS

Purpose of Disclosure (i.e. individual's request, insurance, continuing care): _____

This authorization to release health care information will expire twelve months after its execution. This authorization may be revoked at any time by notifying the practice in writing at _____, but this will not affect disclosures made prior to receipt of the revocation.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization. Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to redisclosure by the recipient and will no longer be protected by these laws. By signing this Authorization, I acknowledge that I have read it and that I understand it.

_____ _____
Signature of patient or authorized representative — Date

_____
Description of authorized representative's authority to sign

_____
Witness

※–RELEASE ※