LOG ID _____

Holland Hospital

602 Michigan Avenue, Holland, Michigan 49423-4999, (616) 392-5141

Authorization To Release/ Obtain Medical Information

Please check all appropriate boxes.

Last Name | First Name | Date of Birth | MR#

Maiden Name / AKA | Phone Number | E-Mail | PIN #

I hereby authorize Holland Hospital to ☐ disclose and/or ☐ obtain the following information contained in my medical record from (date)_____ to (date)_____.

Name of person/organization to whom disclosure is to be released/obtained from:

Name: _____ City _____ State _____

Address: _____ Zip Code _____

Specific Information Authorized for Release

☐ Complete Medical Record
☐ E.R. Reports
☐ Discharge Summary
☐ History & Physical
☐ EKG(s)
☐ XRay Reports/Film, Digital, CD
☐ Progress Notes
☐ Operative Report
☐ Rehab Services Report / O.T., P.T., Cardiac
☐ Pathology Report(s) / Lab
☐ Mail/Verbal Acn#_____
☐ Billing Records
☐ Other_____
☐ Treatment Plan/Planning
☐ Psychiatric History & Physical
☐ Psychiatric Evaluation
☐ Psychiatric Discharge Summary
☐ Psychiatric Testing

Purpose of Disclosure

☐ Attorney/Legal ☐ Insurance/Workers Comp. ☐ Personal Reasons ☐ Treatment

I understand that this will include information relating to:
- Acquired Immunodeficiency Syndrome (AIDS) or Infection with HIV (Human Immunodeficiency Virus), Aids related complex (ARC).
- Sexually transmitted diseases, Tuberculosis, Hepatitis, Communicable diseases and Infectious disease.
- Treatment for Alcohol and/or Drug Abuse
- Behavioral Health Services

Release of Information

1. I understand that this authorization extends to all medical records of other providers to the extent indicated above; this may include any information about substance abuse treatment, behavioral health services, communicable diseases and infectious disease, including sexually transmitted disease, HIV infection, acquired immunodeficiency related complex, venereal disease, hepatitis or tuberculosis.
2. I understand that I may inspect or copy the information to be disclosed and may, upon inspection, refuse to sign the authorization or may revoke this authorization at any time if already signed by sending a written revocation to the Medical Records Department at Holland Hospital. I understand that the revocation will not apply to information that already has been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify expiration date, event or condition, this authorization will expire in six (6) months.
3. I understand that any disclosure of this information carriers with it the potential for redisclosure and the information may not be protected by federal or state confidentiality regulations/rules.
4. I understand that my continued or future treatment by or payment to Holland Hospital is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.
5. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure continued or future treatment.

☐ I have been provided a copy of this authorization for my records.

X _____ Date:_____
Signature of Patient or Person Authorized to Consent
Note: If signature is marked by X you must have two witnesses.

X _____
Relationship, if not Patient, Legal guardian - **attach documentation**

X _____ X _____
Witness Witness

If you have any questions, please call Holland Hospital Medical Records Department at (616) 394-3154 or fax to (616) 394-3285.

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