MRN: _____

PATIENT INFORMATION RELEASE AUTHORIZATION

Patient Full Name: _____ Maiden Name: _____
First Initial Last

Date of Birth _____ SS#: _____ Sex: M/F Telephone: (___) _____

Address: Street: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____, its director or agent to release information contained in the medical record of the patient identified above which includes information that may be stored in paper and/or electronic format. This includes records concerning general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; and demographic information. ***Not for use for disclosure of psychotherapy notes.***

1. Name or title of person or organization and address to whom information is to be:

☑ **Disclosed To:** Axiom Requisition Copy Service ☐ Requested From: _____

447 North Canal Road

Lansing, MI 48917

Address Address

2. The purpose or need for such disclosure

XXX at the request of the patient ____ Personal Use ____ Continuation of Care XXX Attorney

____ Workman's Compensation ____ Insurance ____ Disability ____ Other _____

3. Specific information to be disclosed/obtained as related to #2. (indicate date of service):

____ ER Memo _____ ____ Outpatient Visit _____

____ X-Ray/Lab _____ ____ Discharge Summary _____

____ Immunizations _____ ____ Entire Record (last two years) _____

____ Other _____

4. This authorization is valid only if received by Henry Ford Health System within 90 days of the date signed. I may revoke this authorization anytime. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

5. HFHS does not condition treatment on whether this authorization is signed.

6. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no loner be protected by law.

7. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copy information. This fee is waived when releasing information **directly** to a treating physician or health care facility.

Signature:_____ Relationship (if other than patient): _____
Patient, Parent or Minor, Legal Guardian, Personal Representative*

Date: _____

Witness Signature: _____ Date: _____

*If Legal Guardian or Personal Representative, a copy of appropriate documentation is necessary for release.

MRN: _____

PATIENT AUTHORIZATION FOR DISCLOSURE
PSYCHOTHERAPY NOTES

Patient Full Name: _____
First Initial Last

I, _____hereby authorize _____, its director or agent, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format as set forth below. This authorization is for the disclosure of psychotherapy notes only. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers.

1. Name or title of person or organization and address to whom information is to be:

☑ Disclosed To: Axiom Requisition Copy Service
447 North Canal Road
Lansing, MI 48917
Address

☐ Requested From: _____
Address

2. The purpose or need for such disclosure

XXX at the request of the patient ____ Personal Use ____ Continuation of Care XXX Attorney

____ Workman's Compensation ____ Insurance ____ Disability ____ Other _____

3. The psychotherapy notes to be disclosed are for the dates of service indicated below.

DATES OF SERVICE_____ DATES OF SERVICE_____

_____ _____

4. This authorization is valid only if received by Henry Ford Health System within 90 days of the date signed. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

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