Trinity Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label

(One Patient Per Form)

Patient Name:_____ Date of Birth:_____

Street Address:_____ Telephone: ( )_____

City, State, Zip:_____ Email Address:_____

Release Information From:

☐ **Trinity Health Grand Rapids Hospital**
Attn HIM Dept
200 Jefferson SE
Grand Rapids, MI 49503
F: 616-685-3014
P: 616-685-6166

☐ **Trinity Health Grand Rapids Hospital**
Attn Central Medical Records (doctor's office)
200 Jefferson SE
Grand Rapids, MI 49503
F: 616-685-3194
P: 616-685-3180

☐ **Trinity Health Imaging Grand Rapids Hospital**
F: 616-685-3011
P: 616-685-6214
E: film.room@trinity-health.org

Other: _____
Name

_____
Address

_____
Phone Fax

Release Information To:

☐ **Trinity Health Grand Rapids Hospital**
200 Jefferson SE Grand Rapids, MI 49503
F: 616-685-3014
P: 616-685-6166

☐ **Trinity Health Grand Rapids Hospital**
Attn Central Medical Records (doctor's office)
200 Jefferson SE
Grand Rapids, MI 49503
F: 616-685-3194
P: 616-685-3180

Other: _____
Name

_____
Address

_____
Phone Fax

PURPOSE OF RELEASE (check reason):

☐ Personal ☐ Continuity of Care ☐ Insurance ☐ Legal ☐ Transfer Out

Fill in dates of treatment for records to be released:

Treatment dates: From_____ **To**_____

Hospital Record (check all that apply):

☐	Discharge Summary	☐	Cardiac Reports/EKG
☐	History & Physical	☐	X-Ray Images
☐	Consultation Reports	☐	Oncology Reports
☐	Operative Reports	☐	Psychiatric/Behavioral Health Records
☐	Laboratory Reports	☐	Other
☐	Radiology/X-Ray Reports	☐	Entire Record
☐	Pathology Reports	☐	*Billing Records (mailed only)

Doctor Office Record (check all that apply):

☐	Office Visits
☐	Outside Consult Notes
☐	Laboratory Reports
☐	Radiology Reports
☐	Other:
☐	Billing Record
☐	
☐	Entire Record

FORMAT(Charges may apply):

☐	CD
☐	Paper Copy
☐	Other:

DELIVERY METHOD:

☐	Pick-up
☐	Mail
☐	Fax (Hosp. or Phys. Office only) Fax #

Sensitive Information: I request the following Information be released, which may include: alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purposes and conditions designated on this form.

Right to Revoke (cancelling) authorization: I have the right to revoke (cancel) this limited authorization in writing at any time. Revocations must be made in writing and sent to Trinity Health Release of Information with the address on the top of this form. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy or the policy itself.
Note: Once information has been disclosed, Trinity Health can no longer protect it from further disclosure.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event, or condition, this authorization will expire in six months.

Re-disclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be re-disclosed and no longer protected by these regulations.

Signature:_____ **Print Name:**_____ **Date:**_____
Only hand signature accepted

☐ **ID Checked** **Employee Name:**_____ **Date:**_____

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at law, etc. ***BILLING: Billing information will be mailed to the address stated above unless otherwise specified.**