Authorization to Disclose Health Information

Patient Name:________________________________ **Medical Record Number:**________________

Date of Birth:______________ **Phone Number:**__________________ **Account Number:**________________

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:
   Trinity Health Livonia Hospital • 36475 Five Mile Road • Livonia, Michigan 48154

3. The type and amount of information to be used or disclosed is as follows: (include Date of Service where appropriate)
   - ☐ Emergency Room Record ➤ Date of Service:__________________
   - ☐ Pertinent Package (History & Physical, Discharge Summary, Consultations, all Diagnostic Testing Results)
     Date of Service:__________________
   - ☐ Most Recent History & Physical
   - ☐ Most Recent Discharge Summary
   - ☐ Laboratory Results ➤ Date of Service:__________________
   - ☐ X-ray and Imaging Reports ➤ Date of Service:__________________
   - ☐ Entire Record
   - ☐ Other ____

   ____

4 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 about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:
   Release Records to: ____________________________________
   Address: ____
   For the Purpose of: ____________________________________

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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 six (6) months.

7. I understand 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Medical Records or the Hospital's Privacy Official.

______________________________ ____________ __________
Signature of Patient or Legal Representative — Date — Time

______________________________ ________________ ________ ________
If Signed by Legal Representative, Relationship to Patient — Signature of Witness — Date — Time

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Email

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