DMC DETROIT MEDICAL CENTER

☐ CHM ☐ HWH
☐ DRH ☐ KEI
☐ DSH ☐ RIM
☐ HUH ☐ SGH
☐ HVSH ☐ _____

321

Patient Label

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(NOT FOR PSYCHOTHERAPY NOTES)

Patient Name _____ Date of Birth ___/___/_____

Social Security # _____-____-_____ Maiden / Other Name _____

Patient Address _____
Street City State Zip

Phone Number _____

I authorize _____
Healthcare facility / physician
to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services)

Name to whom information may be released:_____

_____
Address City State Zip Code

_____
Area Code Telephone Number Fax Number

Date(s) of Treatment: _____

Specific Type of Information to be Disclosed

☐ Discharge Summary ☐ X-Ray Reports ☐ ED Reports
☐ History & Physical ☐ X-Ray Images / CD
☐ Consultations ☐ Operative Reports
☐ Laboratory Results ☐ Pathology Reports ☐ Other(specify): _____

Method of Disclosure

☐ Paper
☐ CD / DVD format, where available
☐ Other(specify): _____

The Purpose and Need for Such Disclosure: _____

_____

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ ___/___/_____
Signature of Patient / Parent / Personal Representative Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

_____ _____
Relationship to Patient Print Name

Source of Authority _____

COPYING OF MEDICAL RECORDS

The Detroit Medical Center (DMC) has contracted with HealthPort to process your request for medical records. The State of Michigan has become a regulated state for the pricing of copying medical records and the following rates went to effect

February 19, 2015

COPIES FOR PATIENTS. There will be a charge to patients for medical record requests. The charge for this service will be:

$1 .18	per page for pages	1-20
$ .59	per page for pages	21-50
$ .24	per page for pages	51 +

Plus shipping and handling

120 Bluegrass Valley Parkway Alpharetta, GA 30005

If you have any questions please direct your calls to HealthPort Customer Service Department at 1-800-367-1500

I acknowledge that I will receive a statement directly from HealthPort.

By signing this agreement, I hereby acknowledge, I will be responsible for any charges for reproduction of my medical records.

Patient Name: _____

Signature: _____ Date: _____