PATIENT INFORMATION RELEASE AUTHORIZATION

MRN: _____

INSTRUCTIONS
Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

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

Date of Birth: _____ Last 4 Digits of SS# _____ Sex: M / F Telephone: ( ) _____

Address: Street: _____

City: _____ State: _____ Zip: _____

I, _____hereby authorize _____ it's 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. 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. **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: Cefaratti Group
4608 St. Clair Avenue
Cleveland, Ohio 44103
(216)696-1161
Address

☐ Requested From: _____
_____
_____
_____
Address

2. Specific information to be disclosed / obtained**. Indicate date of service**:

____	ER Memo _____	____	Outpatient Visit _____
____	X-Ray /Lab _____	____	Discharge Summary _____
____	Immunizations _____	____	Diagnosis/Dates_____
	Photographs_____	____	Other (specify) _____

3. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.

4. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

5. 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. Contact Referring Physician Office, One Ford Place, Detroit, Michigan 48202

6. My care or treatment will not be conditioned on signing this authorization.

7. 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 longer be protected by law.

8. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying 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 of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

Date: _____

* If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release