Corewell Health™

Authorization for Release of Health Information

Please complete the sections below.

Section 1 Patient Information (please print):

Last Name	First Name	Middle Name

Date of Birth (MM/DD/YY)	Last four digits of Social Security Number or Medical Record Number:	Email address

Street Address	City	State	Zip

Home Phone Number	Cell Number

Section 2 Corewell Health Southeast Michigan Facilities where you received medical care.

☐ Royal Oak ☐ Dearborn ☐ Taylor
☐ Troy ☐ Trenton ☐ Wayne
☐ Grosse Pointe ☐ Farmington Hills ☐ Other _____

Section 3 Specific health information to be released or disclosed. CHOOSE ONE OPTION

Summary (physician reports & test results) for dates of service from: _____ to _____ **OR**

Complete copy of my Medical Record for dates of service from: _____ to _____ (charges may apply)

Other (please describe)_____

Section 4 Purpose of request/disclosure

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Patient Request

☐ Other Please specify:_____

Section 5 What action should be taken? CHOOSE ONE OPTION

☐ Release a copy of my health information to me.

☐ Release my health information to someone else. I have listed where I would like my health information to be sent in Section 6.

☐ Obtain copies of my health information. I have listed the names of the health care providers that I would like you to request my information from in Section 6.

Section 6 Where would you like your information sent? CHOOSE ONE OPTION

☐ I will pick up my health information from the department where I requested the information.

☐ I would like to have it emailed to me at the email address listed in Section 1.

☐ Please mail it to me at the address listed in Section 1.

☐ Please fax it to fax number _____

☐ Release to myBeaumontChart account/patient portal

☐ Please mail it to the address below.

Name

Street Address	City	State	Zip

Phone Number	Fax Number (if the records are to be faxed)

MEDICAL RECORD

Section 7 What format would you like this in? Charges may apply. CHOOSE ONE OPTION

☐ Paper copy

☐ Encrypted (secure) email to the email address provided in Section 1

☐ Unencrypted email to the email address provided in Section 1

☐ Electronically placed on a CD (may not be available at all locations and must be mailed to you)

☐ Release to myBeaumontChart account/patient portal

Important!

Health Information sent in an unencrypted email or on unencrypted media (CD) is not secure. The Health Information may be intercepted and seen by others. There are other risks with unencrypted email including misaddressed or misdirected messages, email accounts that are shared, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted email or on unencrypted media, you are acknowledging and accepting these risks. **Your Social Security Number, home address, insurance information, medical information, and other personal information may appear on the records we are sending to you.**

Section 8 Signature of Patient or Patient Representative

By signing this Authorization, I hereby request and authorize that Corewell Health and its agents and employees, or other health care provider, release the following Protected Health Information or to request medical records from another facility or health care provider. I understand the following:

- My Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- My Health Information may include information about behavioral or mental health services, treatment for alcohol and drug abuse.
- This Authorization is voluntary. My treatment will not be impacted even if I do not sign this Authorization.
- This Authorization is valid for one year from the date that I signed unless another date is listed below.
- I may revoke or withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal or state privacy laws,and could be re-disclosed by the person(s) receiving it.
- If I am not making this request in person, I may be asked to provide a copy of my current driver's license or state identification.
- **There may be a fee associated with my request.**
- This release is being made at my request.

Signature _____ Date _____

Authorization valid for one year from the date signed unless another date is provided here: _____

Please return to: