



CHELSEA HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Printed Patient's Name _____ Phone(____) ____ - ____
Patient's Birthdate _____ Email Address _____
Address _____ City _____ State ____ Zip _____

DESCRIPTION OF MEDICAL RECORDS REQUESTED

Facility from which you are requesting records:

Chelsea Hospital
775 South Main St, Chelsea MI 48118
Other: _____

List Date(s) of Treatment _____

Please select documents to disclose:

- | | | |
|--|--|---|
| <input type="checkbox"/> Emergency Department Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Lab/Pathology Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Test Results (EKG, EEG, echo) | <input type="checkbox"/> X-Ray/Diagnostic Results |
| <input type="checkbox"/> Summary/Abstract Record Set | <i>Specify Test Result</i> _____ | |
| <input type="checkbox"/> Clinic/Physician Office Notes Specify Provider Name _____ | | |
| <input type="checkbox"/> Other (List) _____ | | |

Please include: Radiology Images/CD Itemized Billing Records Complete Medical Record (Fees may apply)

PURPOSE OR NEED FOR THE DISCLOSURE:

- Continued Medical Care Insurance/Payment Legal Reasons Patient's own use
 Other (list) _____

PLEASE DISCLOSE REQUESTED RECORDS TO:

I authorize the medical records indicated above to be provided to the following:

- Patient/Myself Parent/Legal Guardian HIPAA Personal Representative Other, specify below:

Name _____
Address _____
Phone _____ Fax _____

FORMAT REQUESTED: (check only one option)

- Patient Portal/MyChart CD Paper Inspect a copy Email If you choose email, insert email address and choose secured or unsecured below Email address _____
 secured/encrypted email unsecured/unencrypted email *

*If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft. *Please initial if you are requesting unsecured delivery via your personal email listed above. Initials _____

**If records are unable to be emailed due to size limitations, please select an alternate format: Paper or CD

**Records provided on CD or Paper will be sent via the United States Postal Service.



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(Continued on back)

Charges for Access: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results sent to you, the patient's parent or legal guardian, or your HIPAA personal representative. If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service to complete most record requests. You may be invoiced directly by the copy service where applicable. You may request to be notified of any charges for approval prior to having your records sent to you.

Information About Your Access Rights: Except under limited circumstances, we will provide you with access to your records. We will respond to your request within 30 days (or 60 days if the extra time is needed to gather records) from the time we receive this completed form. In certain situations, we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to have the denial reviewed.

I hereby request access to my health information as noted above maintained by Trinity Health System. I understand that the disclosure of my health information MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse, and/or genetic testing.

Please initial below to authorize the disclosure of any of this information

- _____ Alcohol/Drug Abuse or Addiction Diagnosis Treatment
- _____ Behavioral/Mental Health Information
- _____ Communicable Disease, including Sexually Transmitted Disease
- _____ HIV/AIDS Related Information, including testing and treatment
- _____ Genetic Testing
- _____ Reproductive Records
- _____ State Specific Regulations to authorize

If I refuse to sign this Authorization the Trinity Health System will not withhold treatment from me and will not disclose the information to the recipient specified above.

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by the recipient and no longer protected by these regulations.

I understand that I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those prior actions.

This authorization expires on: _____ or upon the following event: _____
(Date)

SIGN HERE _____
Signature of Patient, Parent/Legal Guardian, or HIPAA Personal Representative *Date*

Printed name of patient's Personal Representative, if applicable _____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

Mail request form to:
Chelsea Hospital – Health Information Services Department
775 South Main Street
Chelsea, MI 48118

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 these records. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc.