



General Authorization for Use or Disclosure of Health Information

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

Please select facility from which you are requesting records:

- Trinity Health Ann Arbor Trinity Health Medical Center – Brighton
 Trinity Health Livingston

Other _____

List Date(s) of Treatment _____

Please select documents to disclose:

- Emergency Department Report Discharge Summary History and Physical
 Consultations Operative/Procedure Report Lab/Pathology Results
 Progress Notes Test Results (EKG, EEG, echo) X-Ray/Diagnostic Results
 Summary/Abstract Record Set Specify Test Result _____
 Clinic/Physician Office Notes Specify Provider Name _____
 Other (list) _____

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

PURPOSE OR NEED FOR THE DISCLOSURE IS:

- 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)

- Deliver to 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 (access instructions provided) 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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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 having 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 (customize by ministry if applicable)

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)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)

SIGN HERE

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

Printed name of patient's Parent/Legal Guardian or HIPAA Personal Representative, if applicable _____

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

Mail request form to:

Trinity Health System, Health Information Services Department,
5301 East Huron River Drive, PO Box 995, Ann Arbor, MI, 48106-0995

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. HIPAA personal representative is defined as a person with legal authority to make healthcare decisions on behalf of the individual.