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:

[X] Disclosed To: C D Services, Inc.
24027 Research Drive
Farmington Hills MI, 48335
248-476-1700
Address

[ ] Requested From: HFHS
____
____
____
Address

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

____ ER Memo ____________________
____ X-Ray /Lab ____________________
____ Immunizations ____________________
Photographs____________________
____ Outpatient Visit ________________________
____ Discharge Summary ______________________
____ Diagnosis/Dates________________________
__x__ 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

MRN: ____________________

PATIENT AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY

INSTRUCTIONS
Fill in the appropriate information in each applicable section. Sign and date the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: ________________________________ Maiden Name: ____________________
Last First Initial

Date of Birth: __________ Last 4 digits 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. This authorization is for the disclosure of psychotherapy notes only. 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.

1. Name or title of person or organization and address to whom information is to be:

[x] Disclosed To: C D Services, Inc.
24027 Research Drive
Farmington Hills MI, 48335
248-476-1700
Address

[ ] Requested From: HFHS
Address

2. The purpose or need for such disclosure
 x At the request of the patient ___ Personal Use ___ Continuation of Care x Attorney
 ___ Workman's Compensation ___ Insurance ___ Disability ___ Other: ____________

3. The psychotherapy notes to be disclosed are for the **dates of service** indicated below.

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

5. 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).

6. 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.

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

8. 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.

9. 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 Power of Attorney, a copy of appropriate documentation is necessary for release.

CDS JOB# ________