Holland Hospital
PHYSICIAN OFFICES

Authorization to Release/Obtain Medical Information

Patient Full Name: _____ DOB: _____
Patient Address: _____
Patient Phone Number: _____ Patient Email: _____

Fill Out Both Sections Below

Requesting Medical Records From:

Office Name_____
Address _____
_____
Phone _____ Fax _____

Release Medical Records To:

Name _____
Address _____
_____
Phone _____ Fax _____

Dates of Service: From _____ To _____

Medical Records Being Requested

- ☐ Complete Medical Record
- ☐ Visit Summary
- ☐ Radiology Reports
- ☐ Psychiatric Testing/Evaluation
- ☐ Lab Results/Pathology Reports
- ☐ EKG
- ☐ Immunizations
- ☐ Billing Records
- ☐ Other _____

Purpose of Disclosure

☐ Attorney/Legal ☐ Insurance/Workers Comp ☐ Personal Reasons ☐ Treatment

I understand that this will include information relating to: acquired immunodeficiency syndrome (AIDS), infection with human immunodeficiency virus (HIV), AIDs related complex (ARC), sexually transmitted diseases, tuberculosis, hepatitis, communicable diseases, infectious diseases, treatment for alcohol and/or drug abuse, and/or behavioral health services.

Release of Information

1. I understand that this authorization extends to all medical records of other providers to the extent indicated above; this may include any information about substance abuse treatment, behavioral health services, communicable diseases and infectious diseases, including sexually transmitted diseases, HIV infection, acquired immunodeficiency related complex, venereal disease, hepatitis or tuberculosis.
2. I understand that I may inspect or copy the information to be disclosed and may, upon inspection, refuse to sign the authorization or may revoke this authorization at any time if already signed by sending a written revocation to the Practice Manager at your physician office. I understand that the revocation will not apply to the information that already has been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
   If I fail to specify an expiration date, event or condition, then this authorization will expire in six (6) months.
3. I understand that any disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal or state confidentiality rules or regulations.
4. I understand that my continued or future treatment by or payment to Holland Hospital Physician Offices is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.
5. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive continued or future treatment.
   ☐ I have been provided a copy of this authorization for my records.

Signature of patient or person authorized to consent: _____Date: _____
Relationship, if not patient, legal guardian – attach documentation: _____
Witness: _____ Witness: _____
If you have any questions, please contact the Medical Records Department at 616-394-3154.