Holland Hospital

602 Michigan Avenue, Holland, MI 49423-4999 (616) 392-5141

Authorization to Release/ Obtain Medical Information

Please complete all sections.

Patient Last Name	Patient First Name	Date of Birth	MR#
Maiden Name / AKA	Phone Number	E-Mail	

Date(s) of Service to be released: From _____ **To** _____

I authorize my records to be released from:

Name_____

Address _____

City/State/Zip _____

I authorize my records to be released to:

Name _____

Address _____

City/State/Zip_____

Fax _____

Specific Information Authorized for Release – Check all appropriate boxes

- ☐ E. R. Reports
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes/Consultations
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Operative Report
- ☐ EKG(s)
- ☐ Pathology Report(s) / Lab Results
- ☐ Mail/Verbal Acn# _____
- ☐ Billing Records
- ☐ Other: _____
- ☐ Rehab Services Reports, OT/PT
- ☐ Psychiatric History & Physical
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Discharge Summary
- ☐ Complete Medical Record

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 Medical Records Department at Holland Hospital. 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 redisclosure 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 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: _____

Note: If signature is marked by X you must have two witnesses.

Relationship, if not patient, legal guardian – attach documentation: _____

Witness: _____ Witness: _____

If you have any questions, please call Holland Hospital Medical Records Department at (616) 394-3154 or fax to (616) 394-3285.
Completed forms can be emailed to medicalrecords@hollandhospital.org.