GARDEN CITY HOSPITAL

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____ **Last Four of Social Security #:** _____

Date of Birth: _____ **Phone #:** _____ **Medical Record Number:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make this disclosure.

Name:	**Garden City Hospital**	**CHARGE FOR RECORD**
Address:	Health Information Management 6245 Inkster Rd.	For Paper Copies: *$1 per page for the first 20 copies
City, State, Zip Code:	Garden City, MI 48135 734-458-4405 Fax - 734-421-8371	*$.50 for pages 21-50 *$.20 for pages 51 and over

3. The type and amount of information to be used or disclosed is as follows: (include date when appropriate).

- ☐ Most recent Discharge Summary (Date: _____)
- ☐ Consultation reports (Doctor's name) _____
- ☐ Laboratory results (date) _____ to (date) _____
- ☐ Emergency Room Record from (date) _____ to (date) _____
- ☐ Entire record from (date) _____ to (date) _____
- ☐ X-ray & Imaging from (date) _____ to (date) _____
- ☐ Cardiology Records from (date) _____ to (date) _____
- ☐ Pathology slides and/or report
- ☐ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

   Name: _____

   Address: _____

   City, State: _____

   For the purpose of: _____
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written Revocation to the Health Information Management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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, this authorization will expire in ninety days.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my Health Information Management information, I can contact the Health Information Management Director or the Privacy Officer of Garden City Hospital.

_____
Witness Date

_____
Signature of Patient **Date**

_____
Relationship to Patient

_____
Person Authorized to sign for Patient