Van Buren County Hospital
Simply Remarkable

An Affiliate of MERCYONE

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MRN:_____

Authorization for Release of Health Information

Patient name: _____ **DOB:** _____
Address: _____ **Phone:** _____

I hereby authorize _____ ***to use and/or disclose my health information as follows:***

Disclose to: _____
Recipient Name **Address**

Phone:_____ **Fax:**_____

Purpose(s) of Disclosure: _____

- ☐ Check this box if disclosure is at the request of the individual
- ☐ If the purpose for the disclosure is marketing, check this box only if VBCH will receive direct or indirect remuneration from a third party.

INFORMATION TO BE DISCLOSED: (*check all that apply*)

- ☐ History & Physical Examination
- ☐ Progress notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Consultation Report
- ☐ Other:_____
- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ After Care Plan
- ☐ Financial Record
- ☐ **Complete Record**

I specifically authorize the release of information relating to: (check all that apply)

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ HIV/AIDS related information (including test results)

DATES OF SERVICE OR TIME PERIOD TO BE DISCLOSED: _____
(State time period or "ALL")

I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management.

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at VBCH.
2. Medical Information to be disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
3. This authorization is effective for **12 months** after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to **VBCH HIM Department** . My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient representative **DATE**

_____
Relationship to the patient if signed by personal representative

Office Use Only:
Request completed by:_____ Date: _____
Route of Delivery:_____