Administrative Office
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Pontiac, MI 48341
www.honorcommunityhealth.org

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (H-16.1)

PLEASE COMPLETE AND SIGN THIS FORM TO REQUEST / RELEASE MEDICAL INFORMATION

PATIENT INFORMATION			
Patient Name		Medical Record Number	
Address		Date of Birth	

PURPOSE OF FORM

☐ I am **REQUESTING medical records from another person/entity** to be sent to Honor Community Health.

☐ I authorize and want Honor Community Health to **SEND my medical records to another person/entity**.

MEDICAL RECORDS

Please select all the specific documents that apply to your request

☐ **ALL Medical Records**	☐ Care Plan	☐ Clinical Notes
☐ Clinician Consults	☐ Clinician Orders	☐ History & Physical
☐ Lab Reports	☐ Medication Record	☐ Pathology Reports
☐ Progress Notes	☐ Radiology Reports	☐ Treatment Plan
☐ Session Attendance	☐ Other: _____	

Purpose/reason for release of information: _____

Service dates requested (mm/dd/yyyy): From _____/_____/_____ to _____/_____/_____

This authorization **expires** on (mm/dd/yyyy): _____/_____/_____

RECEIVING OR SENDING PARTY INFORMATION			
Name of Person/Entity		Phone #	
Email		Fax #	
Address			

Return signed & completed form to any of our locations in person or by email at:
medicalrecords@honorcommunityhealth.org

I understand that signing this authorization is voluntary and my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this document.

I request the following information be released, which may include alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purposes and conditions designated on this form.

I understand I may revoke (cancel) this authorization at any time. Revocations (cancellations) must be made in writing and sent to the address listed on this form. Revocations (cancellations) will not apply to information that already has been released.

I understand once information has been disclosed, Honor Community Health can no longer protect it from further disclosure. I have read and understand this form. I authorize the disclosure of my health information as described in this form and sign it voluntarily.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

***If you are signing on behalf of the patient, state your relation to the patient and source of authority. If you are a parent, you must state whether there is a non-custodial parent or parent with joint custody and what role/authority and whether authority is required.*

Print Name: _____ *Relation to Patient:* _____

Source of Authority (attach relevant documents as applicable): _____

PARENTS: *Is there a non-custodial parent or parent with joint custody? ☐ Yes ☐ No*

Is their approval required for the release of medical records or other information? ☐ Yes ☐ No