Ascension
St. John Hospital
NEWLAND MEDICAL ASSOCIATES
www.newlandmedical.com
Phone 248-552-0620

Authorization to Release Patient Health Information

Patient Name: _____ Date Of Birth: _____

Patient Address: _____
(Street) (City, State, Zip Code)

I hereby authorize: _____
(Name of physician, institution, clinic sending records)

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release patient health information to:

Name of Facility: _____

Contact person/title: Attn: Medical Records

Address of facility: _____
Street City, State, Zip Code

Phone Number: 248-552-0620 Fax Number_____

Information to be released: (check all that apply) From: _____ to _____
(dd/mm/yy) (dd/mm/yy)

____ Progress Notes ____ Outpatient Test Reports ____ Inpatient Test Results
____ Laboratory Tests ____ Radiology Reports ____ Operative Report
____ All of the Above

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:

Yes, disclose this information: _____

No, do not disclose this information: _____

Purpose of this Release is:

_____Continuity of Care _____Requested by Patient/Patient Representative _____Other:

_____

NOTICE

Ascension St. John Hospital Newland Medical Associates, and many other organizations and individuals such as hospitals, physicians and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Ascension St. John Hospital Newland Medical Associates, 22301 Foster Winter Drive, 2nd Floor, Southfield, MI 48075. The revocation will take effect when Ascension St. John Hospital Newland Medical Associates, receives it, except to the extent that Ascension St. John Hospital Newland Medical Associates or others have already relied on it.

I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION (may be a specific date or condition. If left blank, the authorization will expire 6 months from date below)

This authorization expires _____/_____/_____
(mm) (dd) (yyyy)

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____AM/PM (Printed Name)

_____
(If signed by someone other than the patient, state your legal relationship to the patient)

_____
(Witness or Translator)

Authorizations signed by a legal representative must include a copy of the guardianship papers or a court certified power of attorney/personal representative document.