



If you need more information from your medical record than what is provided through the Patient Portal, you can request copies of Protected Health Information from Health Information Services (HIS).

1. Print and complete the Release of Information form. Follow the instructions at the bottom of the form to mail or fax it to HIS, or bring it to the department at HGB at 321 East Harris Street in Charlotte, Mich.
2. A driver's license or other government-issued photo ID must be presented when requesting medical records. If picking up someone else's records, you must present your own identification and Durable Power of Attorney paper work, or a signed letter from the patient authorizing release of their protected health information to you. Please bring a copy of the patient's identification as well to avoid delays in the release process.

Q: What are the hours of operation HIS?

A: HIS is open 8 a.m. to 4:30 p.m., Monday through Friday.

Q: How long will it take to get my records?

A: Please allow at least two business days from the time you submit the Release of Information form to process the request. More complicated requests for information that covers multiple visits or entire records may take up to 60 days to process.

Q: Is there a cost?

A: Most of the time, you can receive copies of medical records free of charge, however, charges *may* apply for records obtained as a result of legal or insurance company requests.

Q: Can I receive my child's records?

A: Yes, with the proper identification. Non-custodial parents can obtain records for their minor child(ren), unless legal documentation on file states otherwise. STD and pregnancy results *cannot* be given to the parent of a minor. Records *cannot* be given to parents of emancipated minors.

Q: What if I forget to pick up my records?

A: You may request on the form that your records be faxed or mailed. If you have selected to pick them up in person, but do not do so within 30 days, the copies are destroyed.

Hayes Green Beach Memorial Hospital cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing the authorization, you release HGB from any and all liability resulting from a re-disclosure by the recipient.



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL AREAS OF THIS FORM IN INK. INCOMPLETE FORMS WILL NOT BE PROCESSED.

Patient Name: _____ Date of Birth: _____
Last First Middle

Home Address: _____ Home Telephone: _____

I hereby authorize Hayes Green Beach Memorial Hospital (or other provider releasing to HGB) to disclose my protected health information including copies of my medical record to the person or class of persons listed below.

Other Provider: _____

Recipient/Person: _____ Address: _____

Treatment Dates: _____

INFORMATION TO BE DISCLOSED (check all that apply):

- Discharge Summary Laboratory Results Emergency Room Operative/Procedure Report
- History and Physical Radiology Reports Imaging CD Other _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric assault, domestic violence, genetic testing, sexually transmitted disease, HIV testing, HIV results, or AIDS information.
(Initials) _____

The above information is released for the following purposes only:

- Medical Care Legal Matters Insurance Personal Other

I understand that:

1. I may revoke my authorization at any time in writing, but if I do it will not have any effect on any actions taken prior to my receiving the revocation. Further details may be found in the Notice of Privacy Practices.
2. If the requester or receiver is not a health plan or a health care provider, the release of information may no longer be protected by federal privacy regulations and may be re-disclosed.
3. I understand that I may see and obtain a copy of the information described on this form.
4. I can get a copy of the form after I sign it.
5. This authorization automatically expires once the purpose for which it was signed is accomplished.

I hereby authorize Hayes Green Beach Memorial Hospital to use or release the health information from the medical record of the person listed on this form. I have carefully read this form and agree to disclose the information specified.

Signature of patient _____ Date _____

If the patient is a minor or is otherwise unable to sign, the signature of a parent, guardian or other representative is required.

Signature of personal representative _____ Date _____

Print name _____ Relationship of representative to patient _____

How would you like to receive your records? Pick-up Mail to home address Fax to: _____

Return to: Release of Information – Health Information Services
Hayes Green Beach Memorial Hospital
321 E Harris Street
Charlotte, MI 48813
HGB Phone No. 517-543-1050, ext.15949
HGB Fax No. 517-543-9517