MERCY MEMORIAL HOSPITAL SYSTEM

To obtain copies of medical records or radiology images, please fill out the attached Release of Information authorization form. When filling out the form, please print clearly and remember to fill in all blanks.

Please return the release form to us in one of the following methods:

- Presenting the form to the Mercy Memorial Hospital main Information Desk
- Faxing the form to Health Information Management, 734-240-5334
- Mailing to: Mercy Memorial Hospital System
  Health Information Management
  718 N Macomb St
  Monroe, MI 48162

If records are being mailed or faxed to your physician, this will be done free of charge and most requests are fulfilled in three business days.

Records needed for any other purpose will require payment, which is $5. These requests are usually processed in three business days

Requests for radiology images require one business day for processing. There is no charge for your first copy.

All medical records and radiology images may be picked up from the main information desk at Mercy Memorial Hospital System during the hours of 9am and 8pm Monday through Friday. You will need a valid photo ID when picking up items.

Further questions related to medical records may be directed to release of information within Health Information Management at (734) 240-5367 between the hours of 8:00am and 4:30pm Monday through Friday.

Further questions related to radiology images may be directed to the Radiology Department at (734) 240-5600 between the hours of 8:00am and 4:30pm Monday through Friday.

Please note that your physician or healthcare provider may also contact us to request medical records on your behalf. Health Information Management may be contacted for medical record copies at (734) 240-5367. The Radiology Department may be contacted at (734) 240-5600.

Mercy Memorial Hospital System
Health Information Management
Release of Information
718 N. Macomb
Monroe, Michigan 48162

Phone: (734) 240-5367
Fax: (734) 240-5334

AUTHORIZATION

FOR RELEASE OF PATIENT MEDICAL INFORMATION

For Office Use Only:
Information:
☐ Mailed ☐ Picked Up ☐ Faxed
Date Received: _____
Date Processed: _____
Processed By: _____
Work Order: _____

Please complete this form in its entirety so we can help you receive the information you are requesting.

1. ***This authorization is voluntary. I understand that the Mercy Memorial Hospital System (MMHS) will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document. A separate form is required for release of psychotherapy (progress) notes.***

Patient Name: _____ Date of Birth: _____

Street Address: _____ Telephone: _____

City/State/Zip: _____ Fax: _____

2. ***I am the patient, or the legally authorized representative of the patient, listed above. I request Mercy Memorial Hospital System to release my protected health information (or the patient information listed above) to:***

☐ **Myself** ☐ **Other Person**: _____Company/Organization: _____

Street Address: _____ Telephone: _____

City/State/Zip: _____ Fax: _____

Select delivery method: ☐ Pick Up (72hrs) ☐ US Mail (2 weeks) ☐ View in HPF (Employee only) ☐ CD

3. **Purpose of release/disclosure:**

___ Continuity of Medical Care ____ Payment/Claim Information ____ Personal Use ____ Legal/Attorney

Specific Dates of Service/Care for Information Requested:

Date of service range (month/year):From_____To_____

___Pertinent Package (Discharge Summary, O/R Report, Consults, Lab, Radiology)
___Therapy (PT, OT, Speech..)
___Emergency Room Report
___Discharge Summary
___EKG/Cardiac Treatment
___Progress Notes
___Radiology Reports
___Radiology Images/Reports
___History and Physical
___Laboratory Reports
Physician_____
___Operative Report
___Mental Health Treatment
___Other: _____

4. AUTHORIZATION: I herby authorize Mercy Memorial Hospital System(MMHS) or _____, its director or designee, or Health Information Management Department to release information contained in my patient records, including alcohol/drug abuse records protected under the regulation in 42 Code of Federal Regulations, Part 2, if any, including communication made by me to a social worker, psychiatrist, psychologist and any information regarding communicable diseases and serious infections as defined by Michigan Department of Public Health rule which includes venereal disease, tuberculosis, HIV, AIDS or ARC, if any, to the individuals or organizations listed below, only under the conditions listed above.

5. This authorization will expire in 60 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Mercy Memorial Hospital has relied upon it. For example, if I cancel it after Mercy Memorial Hospital has sent records Mercy Memorial Hospital will not retrieve those records. Instructions for cancelling this authorization are included in the Mercy Memorial Hospital Notice of Privacy Practices. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and **there will be fees associated with most record requests.**
*Please be advised that Michigan Law MCL 333.26269 allows us to waive the charge for continuity of care.

6.

_____ _____/___/_____
Signature of Patient or Legally Authorized Representative (if patient is minor or unable to sign) **DATE** (mm/dd/yyyy)

_____ ____/____/_____
Signature of Witness **ID Verified**: ☐ Yes ☐ No **DATE** (mm/dd/yyyy)

7. Payment: There will be fees associated with most record requests. Payment must be received before you receive the requested records. Should your record fees exceed $50.00, you will be contacted to approve the fee before your request will be processed.
Paper Record fees will be billed as follows:
$5.00 per paper record request
*****Requests under 5 pages will be free***
Film/CD Record fee:
For non-clinical reasons, the first disc is free. Any additional CD's are $10.00
If films are requested, the first set is free, any additional copies are $5.00 a film

Pages/Films/CD # _____

*Total $*_____