Grand Rapids Home for Veterans
3000 Monroe N.W., Grand Rapids, MI 49505

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Member Name	Member Number	Member Unit	Date of Birth

I, _____ _____, herby authorize Grand Rapids Home for Veterans
(Name) (Name, person, or organization)

3000 Monroe Avenue NE Grand Rapids, MI 49505
(Address)

to release the following information to ___ _____
(Name of Person or Organization)

_____
(Address) (State & Zip Code) (Phone)

☐ Verbal Exchange of Information ☐ Send Information to ☐ Obtain Information From

SPECIFIC INFORMATION TO BE DISCLOSED: (specific information must be checked—No box checked or request for any or all will not be accepted)

Date of Records Needed: from _____ to _____

☐ 1. History and Physical	☐ 7. Initial Assessments
☐ 2. Physician's Progress Notes	☐ 8. Assessments
☐ 3. Interdisciplinary Progress Notes	☐ 9. X-rays/Labs/EKG
☐ 4. Social Worker Progress Notes	☐ 10. Other
☐ 5. Therapy Notes ___PT ___OT ___Speech ___Activity	☐ 11. Other
☐ 6. Medications(s)	☐ 12. Other

Any information not to be released:

_____

Reason for Disclosure:

_____

This Authorization is good for this request only. I understand that my records are protected by State and Federal Confidentiality Rules and cannot be disclosed without my written consent unless release is required by other regulations. I also understand that I may revoke this consent at any time in writing to the Grand Rapids Home For Veterans Privacy Officer, except to the extent that action has already been taken. I understand that medical information may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, and ARC. I understand that treatment, payment, enrollment or eligibility for services will not be conditioned on signing this authorization. I understand there is the possibility the protected health information may be re-disclosed by the recipient of the information and no longer protected by the Privacy Rules.

_____ _____
Member Signature Date

_____ _____
Signature of Legal Representative Date

_____ _____
Description of Authority to Sign for Member i.e., DPOA-POA-Guardian Signature of Witness

NOTE: Faxed and Photocopied authorizations are accepted only under specific circumstances.