Payment: There will be fees associated with most record requests. In some cases, payment must be received prior of record release.

(One Patient Per Form)

Patient Name:________________ Date of Birth:________________

Street Address:________________ Telephone: (   )________________

City, State, Zip:________________ Email Address:________________

Release Information From:

☐ **Saint Mary's Hospital**
200 Jefferson SE
Grand Rapids, MI 49503
F: 616-685-3014
P: 616-685-6166

☐ **Mercy Health Physician Partners (doctor's office)**
1900 44th St
Kentwood, MI 49508
F: 616-685-3194
P: 616-685-3180

☐ **Saint Mary's Radiology**
F: 616-685-3011
P: 616-685-6214

Other: ________________
Name
____
Address
____
Phone   Fax

Release Information To:

☐ **Saint Mary's Hospital**
200 Jefferson SE
Grand Rapids, MI 49503
F: 616-685-3014
P: 616-685-6166

☐ **Mercy Health Physician Partners (doctor's office)**
1900 44th St
Kentwood, MI 49508
F: 616-685-3194
P: 616-685-3180

Other: ________________
Name
RECORDS DEPOSITION SERVICE, INC.
Address
PO BOX 5054, SOUTHFIELD, MI, 48086-5054
Phone 248-357-3330   Fax 248-357-3337

PURPOSE OF RELEASE (check reason):
☐ Personal ☐ Continuity of Care ☐ Insurance ☒ Legal ☐ Transfer Out

Fill in dates of treatment for records to be released:
Treatment dates: From________________ To________________

Hospital Record (check all that apply):

☐	Discharge Summary	☐	Cardiac Reports/EKG
☐	History & Physical	☐	X-Ray Images
☐	Consultation Reports	☐	Oncology Reports
☐	Operative Reports	☐	Psychiatric/Behavioral Health Records
☐	Laboratory Reports	☐	Other
☐	Radiology/X-Ray Reports	☐	Entire Record
☐	Pathology Reports	☐	*Billing Records (mailed only)

Doctor Office Record (check all that apply):

☐	Office Visits
☐	Outside Consult Notes
☐	Laboratory Reports
☐	Radiology Reports
☐	Other:
☐	Billing Record
☐	
☐	Entire Record

FORMAT(Charges may apply):

☐	CD
☐	Paper Copy
☐	Other:

DELIVERY METHOD:

☐	Pick-up
☐	Mail
☐	Fax (Hosp. or Phys. Office only) Fax #

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, except to the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires, as noted below.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event, or condition, this authorization will expire in six months.

Re-disclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above my be re-disclosed and no longer protected by these regulations.

Signature:________________ **Print Name:**________________ **Date:**________________

☐ **ID Checked**   **Employee Name:**________________ **Date:**________________

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at law, etc.

***BILLING: Billing information will be mailed to the address stated above unless otherwise specified.**