Guidelines for Patient’s Obtaining Copies of Medical Records

1) A Release of Information Authorization form is required for any patient to obtain copies of records.

2) Gratiot Medical Center and its authorized employees may only FAX patient records for continuation of care purposes to other healthcare organizations and/or physician offices. For patient privacy reasons, Gratiot Medical Center is unable to FAX patient records to patient homes or places of employment. All other requests may be picked-up or mailed.

3) There is a charge for copies. Both state law and federal law (HIPAA) permit healthcare organizations to charge a reasonable cost-based fee for reproducing records. Our fee, updated annually in July, is based on the Consumer Price Index of Medical Records Access Act Fees from the State of Michigan’s Department of Community Health. The fee includes the cost of labor, supplies, and when applicable postage, and shipping. Gratiot Medical Center’s fee schedule is as follows:

- Pages 1-20……………………………..…$1.00 per page
- Pages 21-50………………………………….50¢ per page
- Pages 51+………………………………………… .. 20¢ per page
- Shipping & Handling (when applicable)……..actual charge

Prices effective July 1, 2010 through June 30, 2011.

For mailed requests, an invoice will be sent with the copies. For requests picked-up by the patient, payment is expected at the time of pick-up. For your convenience, Gratiot Medical Center accepts cash, checks made payable to Gratiot Medical Center, Visa, Mastercard, and Discover. Please do not mail cash. Receipts are available upon request.

The above fee may be avoided if the records are sent directly to the healthcare organization or physician office.

4) The Release of Information Authorization must be completed in its entirety. Page two (2) is only required when consent is received by an individual other than the patient or the records will be picked up by an individual other than the patient.

5) When consent is received by an individual other than the patient, proof of personal representative must be attached. Parents of children with a different last name must provide proof of paternity through a birth certificate, affidavit of parentage, or other legal document.

6) State of federally issued photo ID is required to pick up records.

7) You may wish to use the FAX cover page supplied at the end of this document to FAX the Release of Information Authorization to the Medical Data Services Department. Or you may wish to mail the Release of Information Authorization. Please mail it to:

   Gratiot Medical Center
   Medical Data Services
   Attn: ROI Coordinator
   300 East Warwick Drive
   Alma, Michigan 48801

   Please include your contact information for questions related to the request.

8) If you have any questions, please contact the Release of Information Coordinator at (989) 466-3283.

We realize that this is an involved process and apologize in advance for any inconvenience. It is for the safety of our patients that we are not authorized to release information over the phone or without a signed release of information authorization. We thank for your help and understanding. We look forward to serving you soon.
Release Of Information Authorization

I authorize the use or disclosure of the above named individual’s health information as described below.

1. The following individual or organization is authorized to make the disclosure:
   - ☐ Authorized employees of Gratiot Medical Center, 300 E. Warwick Drive, Alma, Michigan 48801
   - ☐ Other: ____________________________________________

2. The type and amount of information to be used or disclosed is as follows: (include dates of service)
   - ☐ Consultation Report(s)____________
   - ☐ Discharge Summary___________
   - ☐ Echocardiogram(s)____________
   - ☐ EKG(s)_______________________
   - ☐ Emergency Record(s)__________
   - ☐ History & Physical(s)__________
   - ☐ Laboratory Result(s)___________
   - ☐ Operative Report(s)__________
   - ☐ Pathology Report(s)___________
   - ☐ Entire Record or Abstract___________
   - ☐ Pathology Slide(s)____________
   - ☐ X-ray Report(s)________________
   - ☐ X-ray Film(s)__________________
   - ☐ Other (must be specific)__________

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

4. This information may be disclosed to and used by the following individual or organization:
   - ☐ Self
   - ☐ Gratiot Medical Center, 300 E. Warwick Drive, Alma, Michigan 48801
   - ☐ Other (must be specific) __________________________________________

   Address or FAX & Phone (required):

5. The purpose and need for disclosure:
   - ☐ At the request of the patient
   - ☐ Continuation of Care
   - ☐ Employment Purposes
   - ☐ Other (must be specific) __________________________________________

   ☐ School/Education Purposes
   - ☐ Legal Purposes
   - ☐ Social Services Referral
   - ☐ Insurance Purposes
   - ☐ Workman’s Compensation

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Data Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months from the date signed.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the Medical Data Services Department at Gratiot Medical Center.

I hereby certify that I am 18 years of age or older.

Patient Signature ______________________________ Date Signed __________________________

Staff Signature ______________________________

Witness __________________ Date________________
Witness __________________ Date________________

FOR USE ONLY WHEN AUTHORIZATION SIGNED “X” BY PATIENT

See reverse side for “OFFICE USE ONLY” section
### AUTHORIZATION FOR RECORD PICK-UP BY OTHER THAN PATIENT

If the patient is unable or unwilling to pick-up the copies of their medical records and wishes to authorize another individual to obtain the copies, the following must be completed:

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>NAME OF AUTHORIZED INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

To pick-up my confidential medical records as outlined on page one (1) of this document.

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td></td>
</tr>
</tbody>
</table>

**TO BE COMPLETED AT TIME OF PICK-UP**

<table>
<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED INDIVIDUAL</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF SIGNATURE</th>
<th>Date</th>
<th>□ Verified by photo identification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CONSENT BY OTHER THAN PATIENT

If the patient is under 18 years of age OR otherwise unable to consent, the following must be completed:

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATION TO PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

patient, that the patient is unable to consent because he/she is a minor _______ years of age OR because ________________________________.

On behalf of ________________ I consent to disclosure as outlined on page one (1).

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE OF PARENT, GUARDIAN, ADMINISTRATOR, ETC.</th>
<th>ADDRESS</th>
<th>Date</th>
<th>□ Verified by photo identification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF SIGNATURE</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OFFICE USE ONLY**

- Records needed by:
  - (indicate date/time)
  - □ Urgent  □ ASAP  □ Routine

- □ There is a fee for record copies
- □ Mail records - address on reverse side
- □ Call when records are ready - telephone number on reverse side
- □ Patient pickup  □ Patient rep pick-up
- □ Please bring photo ID

**FEE FOR COPIES**

$__________._______ for _______ pages

- □ Invoice Mailed
- □ Fee waived per
  - □ Management ______
  - □ MidMichigan employee
  - □ Indigent (proof attached)
  - □ Continuation of care –
    - □ Mailed
    - □ Fax

**NOTES:**

Patient notified by _______ by phone on _______ that records are ready for pickup.

<table>
<thead>
<tr>
<th>CLERK INITIALS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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Rev. 06/08
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FAX Cover Sheet

To
Gratiot Medical Center
Medical Data Services Department
Attn: Release of Information Coordinator
300 East Warwick Drive, Alma, MI 48801

Phone (989) 466-3283
FAX (989) 466-3377

From

Phone (___)
FAX (___)

Transmission Date ___/___/____ Time ____:____ [□ AM □ PM]
Number of Pages (including cover) _________
Additional Comments ____________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

If you do not receive all of the pages, please call _________________ as soon as possible.