

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All blanks MUST be filled in)

Patient Name: _____ Date of Birth: _____

Address: _____ Soc. Sec. No.: _____

Telephone: _____

Released From (Health Care Provider name): _____ Released To: _____

I authorize the Health Care Provider to release information contained in the medical record of the patient identified above, including information stored in a paper or electronic format. This authorization includes:

(a) Information concerning communicable disease and infection information including venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC) protected under Michigan Public Act 174 of 1989, as amended.

(b) Substance abuse information protected under 42 Code of Federal Regulations, Part 2.

(c) Social and psychological information including communications made to a social worker or psychologist to the Health Care Provider.

Specific information to be disclosed:

_____ Any and All Records _____ Diagnostic Reports Only _____ Laboratory Results Only
_____ Immunizations _____ Chart Notes Only _____ Consultations Only
_____ Discharge Summary _____ Other (*describe*) _____

Date or date(s) of service: _____

The purpose and need for disclosure:

_____ Transfer of Care _____ Attorney Request _____ Disability
_____ Worker's Comp _____ Social Security _____ Insurance
_____ Other (*describe*) _____

I understand that I may revoke this authorization by notifying, in writing, the Health Care Provider. I understand that a revocation will not apply to the information the Health Care Provider already released under this authorization.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.

I understand the Health Care Provider will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide this authorization.

I understand that information that the Health Care Provider releases under this authorization may be subject to a re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization expires after one year unless I revoke it sooner.

Signature (Patient, Parent of Minor, Legal Guardian,
Personal Representative)

Print name of person signing

Date signed: _____

Relationship (if other than patient)