AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Important: All blanks MUST be filled in, & please use one form for each physician you are requesting information from

Patient: _____ Birthdate: _____

Address: _____ SSN: XXX-XX- _____

_____ Phone #: _____

RELEASE INFORMATION FROM:

[ ] Little Traverse Primary Care OR **[ ]** Other (Where are records being requested from)

N.P. or Dr. _____ Name/Physician: _____

Mailing address: 8881 M-119 Address: _____

Harbor Springs, MI 49740 City/State/Zip: _____

PHONE#: 231-622-6550 Phone #: _____

FAX#: 231-627-2504 Fax #: _____

RELEASE INFORMATION TO:

[ ] Little Traverse Primary Care OR **[ ]** Other (Where are records going to)

N.P. or Dr. _____ Name/Physician: _____

PHONE#: 231-622-6550 Address: _____

FAX#: 231-627-2504 City/State/Zip: _____

Phone #: _____

Fax #: _____

Email Address:_____

SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED: ☐ Most recent progress note/annual exam

☐ Diagnostic Reports (Past two years plus most recent colonoscopy, cardiac cath./testing, EKG, DEXA, mammogram)

☐ Laboratory Results (Past two yrs. or most recent) ☐ Immunizations ☐ Diabetic Eye Exam

☐ Consultations (Past two years) Other_____ Date(s) of Service _____

Without expressed written revocation; this consent expires after two years.

Please initial the following:

_____Communicable disease and infection information as defined by statue and Michigan Department of Public Health Rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDA", and AIDS related complex "ARC".

_____Alcohol and/or drug abuse treatment information protected under regulation in 42 Code of Federal Regulations, Part 2.

_____ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

IS A COPY ON A CD OKAY? ____ I WANT A PAPER COPY. ____ (see price list on back)

THE PURPOSE AND NEED FOR DISCLOSURE: ☐ Continuation of Care ☐ Transfer of Care ☐ Attorney

☐ Disability ☐ Workers' Comp ☐ Social Security ☐ Insurance ☐ At My Request

☐ Other _____ (You will be charged for records if you check "Other" or "At My Request")

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
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 that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.

Please indicate your legal authority and include documentation of your relationship:

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

- If the patient is 17 years of age or older, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

☐ Parent ☐ Legal Guardian

Signature: _____ **Date:** _____

Printed Name of Person Signing (If Not Patient) _____

Witness: _____ **Date:** _____