AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient: _____ Birthdate: _____
Address: _____ SSN: XXX-XX- _____
_____ Phone #: _____

RELEASE INFORMATION FROM:

Little Traverse Primary Care
P.A. or Dr. _____
722 S. Main Street
Cheboygan, MI 49721
PHONE#: 231-622-6550
FAX#: 844-432-5695

RELEASE INFORMATION TO :

Name / Physician:_____
Address:_____
City/State/Zip:_____
Phone #: _____
Fax #: _____

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

☐ Diagnostic Reports (All records since 12/18/2017, plus most recent colonoscopy, cardiac cath./testing, EKG, DEXA, mammogram)

☐ Laboratory Results (All records since 12/18/2017) ☐ Immunizations

☐ Consultations (All records since 12/18/2017)

Other_____

I understand the following information may be disclosed:

__ 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.

THE PURPOSE AND NEED FOR DISCLOSURE: Transfer of Care

Without expressed written revocation; this consent expires after one year.

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:** _____

Fees for Copying Records:

- If you request a medical record transfer including records from dates December 18, 2017 to present, and your provider accepts the record transfer via CD or fax, then your records will be provided to the physician **FREE OF CHARGE**.

- If you require any records dated before December 18, 2017, which reside in our archive database, our third party record management company will be notified and there will be a $25.00 fee paid in advance in order to process your request.

- If the physician you are transferring to does not does not accept records via CD or fax, you will be liable for the per page fee to be paid before records are printed. The charges are as follows:

  - $1.25 per page for the first 20 pages;
  - 63 cents per page for pages 21-50;
  - 25 cents per page for pages 51 and over.