

A F Associates Family Medicine, PC
2849 Michigan Street NE
Grand Rapids, MI 49506
Ph (616)285-6450 Fax (616)285-6455

Authorization for Release of Protected Health Information

Please print all information, then sign and date form at bottom.

Patient Name: _____ DOB: _____
 Address: _____ Phone: _____
 City, State, Zip: _____ Date(s) of Service: _____

Information Requested:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Consult Letters | <input type="checkbox"/> Hospital Inpatient |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> ER Reports | <input type="checkbox"/> Billing Invoices |
| <input type="checkbox"/> Lab/Path Reports | <input type="checkbox"/> EKG/Holter Monitor | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Other _____ | | | |

I would like copies of my health information indicated in the section above sent :

From: _____ To: _____
 Address: _____ Address: _____
 City, State, Zip: _____ City, State, Zip: _____

I authorize release of health information, contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statute and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C; Human Immunodeficiency Virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS).
- Alcohol and drug abuse treatment information.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Purpose of Disclosure:

- | | | | |
|--|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Transfer to new PCP. Dr. _____ | <input type="checkbox"/> Other _____ | |

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization or person. I further understand that correspondence from healthcare providers other than AF Associates Family Medicine, will not be released unless specifically requested above.

This authorization will expire **60 days** from the date signed unless you specify an earlier/later termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list an expiration date if more/less than **60 days**): _____.

I understand that Health Information that is released under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Health Information may no longer be protected by law.

 Signature of Patient or Legal Representative Date Relationship to Patient