7.31

A+ Family Medicine, PC

2849 Michigan Street NE
Grand Rapids, MI 49506
Phone (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:

□ History & Physical	□ Immunizations	□ Consult Letters	□ Hospital Inpatient
□ Progress Notes	□ Radiology Reports	□ ER Reports	□ Billing Invoices
□ Lab/Path Reports	□ EKG/Holter Monitor	□ Operative Reports	□ Behavioral Health

□ All Records

□ 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 statue and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C; Human Immunodeficiency Virus (HIV), and 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:

□ Attorney/Legal □ Continued Patient Care □ Insurance □ Personal Use
□ Worker's Compensation □ Transfer to new PCP. Dr._____
□ 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 A+ 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