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Authorization to Release Information

Print Patient's Name _____ Birth Date _____ Telephone Number _____

Address _____

I authorize _____ to release to _____
(name) (name)

(address) (address)

(city, state, zip) (city, state, zip)

(telephone/fax) (telephone/fax)

Specific type of information to be disclosed: Date(s) of Service: _____ to _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Treatment/Care Information |
| <input type="checkbox"/> Test Reports | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> All Medical Records |
| <input type="checkbox"/> Work Status Reports | <input type="checkbox"/> Physical Therapy Reports | <input type="checkbox"/> Other: _____ |

The purpose and need for disclosure:

- | | | |
|---|---|--|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Personal | <input type="checkbox"/> Insurance Billing |
| <input type="checkbox"/> Legal/Attorney | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Other: _____ |

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA/Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than one (1) year after the date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

Signature of Patient or Legal Representative

Today's Date

If Signed by Legal Representative, State Relationship to Patient