Internal Medicine of West Michigan, PLLC

Authorization for Release of Protected Health Information

Date:___/___/___

Patient Name:_____ Date of Birth:___/___/___

Address:

_____

_____ Phone Number:_____

Dates Of Service: ___/___/___ to ___/___/___

___Last Year ___Last 5 years ___Last 10 years ___All Dates

Information Requested:

All Records Required for Transferring to New Physician_____

Emergency Report___ Immunizations:___ Lab/Radiology Report___

Consults/Letter___ Other:_____

From: **Internal Medicine of West Michigan, PLLC**
3200 Eagle Park Drive NE, Suite 102
Grand Rapids, Mi 49525
616 285-9090
Fax: 616 285-7947

To: _____
_____
_____
Phone: _____
Fax: _____

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

1. Information regarding communicable diseases and infections, as defined by statue and Michigan Department of Public Health rules, which include sexually transmitted disease, Tuberculosis, Hepatitis A,B,C,Delta, Human Immunodeficiency virus (HIV) and HIV testing.
2. Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC) and _____ (specify).
3. Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
4. Mental health treatment records, psychologist.

Purpose of Disclosure

_____ Transferring Care _____Insurance _____Worker's Compensation
_____Personal Use _____Other _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in the whole other agency, organization, or person. I further understand that the correspondence, patient discharge instruction and record from healthcare providers, other than from the institution listed above, will not be released unless specifically requested above.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon

Expiration Date: ___/___/___ or action _____

If no express revocation is issued, this authorization will expire in 60 days from date signed.

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 practiced by law.

* A faxed copy of this authorization shall have the same effect as the original.

_____ ___/___/___ _____

Signature of Patient or Legal Representative Date Relationship to Patient

_____ ___/___/___

Witness Date

Internal Medicine of West Michigan, PLLC

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Information Requested: **Please mail records that are more than 20 pages. (Do not fax)**

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