Family Medicine Specialists

721 Three Mile Rd NW Suite 200 Grand Rapids, MI 49544
P: (616) 647-3770 F: (616)647-3788

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth: _____
Address_____
City _____State_____ Zip Code _____ Phone_____

Information requested to be released, please check all that apply to your request.

Please choose why you requesting records;
Transferring PCP_____ **Attorney/Legal**_____ **Patient Request**_____ **Insurance**_____ **Other**_____

- □ Laboratory/Pathology Results
- □ Radiology Reports
- □ Specialist Consult Notes
- □ Operative Reports
- □ Other Documents (please specify, i.e. Behavioral Health) _____
- □ Hospital/ER Notes
- □ Office Notes from Family Medicine Specialists
- □ Entire Chart

Physician/Practice releasing records:
Name: Family Medicine Specialists
Address: 721 Three Mile Rd NW Suite 200
City/State/Zip: Grand Rapids, MI 49544
Phone: (616) 647-3770
Fax: (616) 647-3788

Physician/Practice to receive records:
Name: _____
Address: _____
City/State/Zip:_____
Phone: (_____)_____
Fax: (_____)_____

I authorize the release of these medical records to Family Medicine Specialists to all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment. I agree that the information may be faxed for expediency.

I specifically consent to the disclosure as indicated above that may contain the following information:

- □ Alcohol/drug/substance abuse information _____ (initials)
- □ HIV test results or diagnosis of AIDs and AIDs related conditions _____ (initials)
- □ Mental health information _____ (initials)
- □ Pregnancy information _____ (initials)
- □ Sexually transmitted diseases (STD) information _____ (initials)
- □ Genetic Testing _____ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as follows:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: Family Medicine Specialists Attn: Privacy Contact 721 Three Mile Rd NW Suite 200 Grand Rapids, MI 49544. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party**.** [If applicable because the authorization is obtained for marketing purposes] I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

I understand there may be a fee associated with copying of Medical Records. CIOX (1-800-367-1500) has been contracted to process medical requests and will charge based on the State of Michigan fee schedules.

_____ _____
Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____
Date | Description of Personal Representative's Authority

Revised June 2022