Authorization and Direction

to Release Outpatient Medical

Records and Information

GVSU Family Health Center

72 Sheldon Blvd SE

Grand Rapids, MI 49503

Phone (616) 988-8774

Fax (616) 988-8775

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(In order to obtain your records you will need to provide us with the fax or phone number for this provider.)

and their employees from all provisions of the laws prohibiting hospitals/provider’s offices from disclosing any records, including imaging and laboratory reports of:

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AUTHORIZE THE RELEASE OF INFORMATION AS INDICATED BELOW:**

My Complete Chart

Records Relating to My Visit(s) of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due to the sensitive nature of each item listed below, specific authorization is required for the following information. **Please place your initials on the line(s) next to the appropriate letter if you agree to release that information.**

a.\_\_\_\_\_\_ Information related to treatment of emotional illness, including documentation by any psychologist or psychiatrist.

b.\_\_\_\_\_\_ Documentation by Social Service personnel.

c.\_\_\_\_\_\_ Information related to treatment of alcohol or drug abuse.

d.\_\_\_\_\_\_ Information related to the results of HIV testing, and treatment of HIV infections, AIDS, and AIDS-related complex.

e.\_\_\_\_\_\_ Information related to treatment for venereal disease, tuberculosis, or other communicable disease as specified by the Michigan Department of Public Health.

f.\_\_\_\_\_\_ Information related to visits with prior healthcare providers and/or treatment by other healthcare providers.

This information is to be released to:

**GVSU Family Health Center Bethany Hartrum, FNP-BC Rebecca Sypniewski, DNP, FNP-BC**

**72 Sheldon Blvd SE Ann Sheehan, DNP, CPNP Kimberly Fenbert, DNP, CPNP Grand Rapids, MI 49503 Kathy Watt, NP-C**

**For the purpose of:** Coordination of Care Transfer of Care Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information authorized to be released is for the above purpose only and will not be provided to any other organization, agency, or person, except as required by law. Furthermore, I understand that the possibility of information being disclosed under this authorization may be disclosed by the recipient and may therefore not be protected by HIPAA regulations. This release and authorization is subject to revocation via writing at any time except to the extent that action has been taken. Without revocation, this release and authorization remains valid for one year from the date of my signature below.

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient is under 18 years old or unable to sign.*

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_