Authorization and Direction
To Release Outpatient Medical
Records and Information

GVSU Family Health Center
72 Sheldon Blvd SE
Grand Rapids, MI 49503
Phone (616) 331-9830
Fax (616) 331-9831

Date_____

I hereby release the GVSU Family Health Center and its 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:

Individual or Organization Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

For the purpose of: Coordination of Care Transfer of Care Other_____

This release and authorization is subject to revocationat any time except to the extent that action has been taken.

Signature of Patient_____ Date_____

Signature of Legal Guardian_____ Date_____

Patient is under 18 years old or unable to sign.

Relationship_____ Witness_____