

East Jordan
Family Health Center
601 Bridge Street
East Jordan, MI 49727
(231) 536-2206
Fax: (231) 536-7150

Bellaire
Family Health Center
4955 S M-88 Hwy
Bellaire, MI 49615
(231) 533-8649
Fax: (231) 533-6778

Central Lake
Family Health Center
7960 W. Old State Street
Central Lake, MI 49622
(231) 544-3700
Fax: (231) 544-6987

Authorization for Release of Protected Health Information

Patient's Name

Birth-date

Street

City State Zip Code

Telephone

I hereby authorize:

East Jordan, Bellaire, or Central Lake
Family Health Center, OR

Physician's or Office Name

Street

City State Zip Code

Telephone

to release my confidential health information, as described below, to:

Myself
 East Jordan, Bellaire, or Central Lake Family Health Center

OR

Name

Organization Name

Street

City State Zip Code

in the following manner:

Copies by mail Inspection

Copies by fax Other: _____

Copies to be picked-up

Patient Name: _____ **Birthdate:** _____

for the following purpose(s):

- Continuation of Care At the request of patient Other
-

My authorization is for the use and disclosure of the following records:

- | | |
|---|---|
| <input type="checkbox"/> Progress Notes – 2 most recent | <input type="checkbox"/> Medication List – Current Only |
| <input type="checkbox"/> Labs/Pap reports – 2 most recent | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Diagnostic radiology report/MRI/most recent MAMMOGRAM | |
| <input type="checkbox"/> Hospital Discharge summaries | <input type="checkbox"/> EKG – Most recent |
| <input type="checkbox"/> Other special tests - such as holter monitors, PFT's, sleep studies, etc | |
| <input type="checkbox"/> Other providers/specialists – last 2 years | |

My authorization pertains to information generated on the following date(s) or in the following time period: _____

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- The Health Center may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 30 day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- The Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of the Health Center.
- **I understand that such information to be disclosed may include treatment of Mental Health Information, Substance Abuse and HIV/AIDS related illnesses.**

This authorization will expire on: _____

Patient's Signature *Date*

Signature of Parent or Personal Representative *Date*

Name of Parent or Personal Representative (please print)

Relationship or Description of Legal Authority to Act on Behalf of Patient

Witness Signature

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Bellaire, MI 49615
(231) 533-8649
Fax: (231) 533-6778

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Family Health Center
7960 W. Old State Street
Central Lake, MI 49622
(231) 544-3700
Fax: (231) 544-6987

**Acknowledgement of Receipt
Of Protected Health Information**

I hereby acknowledge that I have received the requested health information for:

Patient Name: _____

In accordance to a valid authorization completed.

Name (please print)

Signature

Date