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. M88 Hwy
Bellaire, MI 49615
(231) 533-8649
Fax: (231) 533-6778

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

☐ Copies by fax

☐ Copies to be picked-up

☐ Inspection

☐ Other: _____

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:

- ☐ Progress Notes – 6 most recent or last two years
- ☐ Medication List – Current Only
- ☐ Labs/Pap reports – 2 most recent
- ☐ Diagnostic radiology report/MRI/most recent Mammogram/ Colonoscopy
- ☐ Hospital Discharge summaries
- ☐ EKG – Most recent
- ☐ Other special tests - such as Holter monitors, PFT's, sleep studies, etc
- ☐ Other providers/specialists – last 2 years
- ☐ Past Medical History- Obstetrics # Birthweight of Child # First OB Visit Notes #EDD
  Name of Child_____ Birthdate_____
- ☐ Dental Records- Office visit notes and treatment plans

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: _____ or one year from date signed**

_____
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 *Date*

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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