Midland Family Physicians, P.C.
920 W. Wackerly Street
Midland, MI 48640
Phone: 989-839-9937 Fax: 989-839-9220
www.midlandfamilyphysicians.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed)

Patient Name: _____Birth Date:_____

Address: _____ Phone: ( ) _____

_____SS#: _____

Release From: Midland Family Physicians
920 W. Wackerly Street
Midland MI 48640

Release to: _____
_____
_____

Specific type of information released: ( ) Any/all records ( ) Diagnostic reports ( ) Lab results
( ) Chart notes ( ) Consultation notes ( ) Operative notes ( ) Other _____
for date range: _____ to _____
(If no time period specified, records from previous 5 years only will be released)

Purpose of disclosure: ( ) Transfer of care ( ) Disability ( ) Worker's Comp ( ) Social Security
( ) Insurance ( ) Attorney request ( ) Other _____

I understand that my medical records may contain information related to communicable diseases and infection information as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD", tuberculosis "TB", Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS", and AIDS Related Complex "ARC"); Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, part 2; and Mental Health treatment records; Psychological services and/or Social Services information including communications made to or by a social worker, psychologist or psychiatrist.

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided by CFR 165.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at the disclosure location.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient

_____
Signature of Witness