

**Authorization to Evaluate, Treat, & Release Records**

**I request and authorize health care services to be provided by Grand Valley State University Health Centers Nurse Practitioners, Nurses, and other members of its health care staff. This includes, but is not limited to, routine diagnostic and/or radiology and laboratory procedures, administration of drugs, biological, and other therapeutic, and routine medical, nursing, and other patient care.**

**I am aware that health care practice is not an exact science and I acknowledge that no oral or written representations of guarantees have been made to me as to the results of any diagnosis, treatment, and health care including, but not limited to, diagnostic procedures, x-rays, and administration of medication that I (or patient) may receive from Grand Valley State University Family Health Center.**

**In addition, I understand that the GVSU Family Health Center is an academic site, and as such may have students involved in my care.**

**I hereby authorize Grand Valley State University Family Health Center to release copies of my health care records, including information from prior treating providers and information about substance treatment, mental illness, HIV infection, acquired immunodeficiency syndrome, acquired immunodeficiency related complex, venereal disease, or tuberculosis;**

1. **To any government agency, medical service organization, insurance company, auditing agency engaged by a third party payer of physician or for the purpose of processing claims for benefits.**
2. **To any health care provider or health care facility to which I (or patient) may be referred to for the purpose of facilitating continuity of care.**

**This release is subject to my (or patient) revocation at any time except to the extent that action has already been taken. Revocation must be in writing.**

**You are hereby-notified pursuant to Michigan law that you may be tested for the presence of HIV, HIV antibody, and Hepatitis B without your consent if any health professional sustains a needle stick or mucous membrane, or open wound exposure to your blood or other body fluids. This test is permitted by Michigan law, and is for your protection as well as the protection of Grand Valley State University.**

**I hereby authorize Grand Valley State University Family Health Center to file an insurance claim and I further assign benefits otherwise payable to me, to Grand Valley State University Health Center. I understand that I am financially responsible for any balance not covered by my insurance carrier.**

**Name of Patient (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of an emergency, I authorize GVSU Family Health Center to release my protected health information to:**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness to Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**