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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_