GRAND VALLEY STATE UNIVERSITY
FAMILY HEALTH CENTER

INSTRUCTIONS: Please complete this form, sign it, and fax it to 616-331-5896.

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_____

*****Due to the closure of the GVSU Family Health Center, the only option available is to receive the complete chart. *****

I authorize the GVSU FHC to release my complete chart to:

This information is to be released to:

Individual or Organization Name: _____
Address: _____
Phone Number: _____ Attn: _____

Recipient Email address: _____

For the purpose of: Transfer of Care

This release and authorization is subject to revocation at any time except to the extent that action has already been taken.

Signature of Patient_____
Date_____

Patient is under 18 years old or unable to sign.

Signature of Legal Guardian_____
Date_____

Relationship_____

Witness_____