Northern Michigan Medicine and Pediatrics

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name	Date of Birth
Previous/Maiden Name(s)	SSN (last 4)

I AUTHORIZE NMMP TO:

Option 1: ☐ Release my medical record ***to*** the individual/organization listed below

OR

Option 2: ☐ Request my medical record ***from*** the individual/organization listed below

Individual/Organization: Address:

Phone: Fax:

TYPE OF RECORDS:

☐ Medical Summary (includes medical/visit history, diagnosis, medications, last vitals, referrals)
☐ Last Visit Summary
☐ Specific Lab, Radiology, Imaging or Test Results (include dates):
☐ Entire Chart **(there may be charges associated with this request, allow extra time for processing)**

Exclude/Other:

☐ **Permanent Change in Physician (Leaving NMMP)** If this box is checked, the patient will be made inactive, visits and orders will be canceled. It is recommended to notify your insurance company of this change.

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of psychiatric, substance abuse, and HIV/AIDS related illnesses. I agree that information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations, Part II, with which this authorization complies. The released information may not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that authorizing the disclosure of health information is voluntary, I can refuse to sign. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.324. I need not sign this form in order to assure treatment.

Authorized Signature	**Date**
Printed Name	**Contact Number**

This request is valid for 1 year after signature date above unless revoked in writing at any time.