Eaton Rapids
Medical Center
Family Practice & Redicare
Springport Medical Clinic

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

*(Patient MRN)*____________________________ *(Date request made)* ________________________

I ____

Full name of patient ***Date of birth***

AUTHORIZE: ☐ Eaton Rapids Medical Center Family Practice/Springport Medical Clinic to use/disclose my health information (as outlined below)

☐ Other: ____ to use/disclose my health information (as outlined below)

TO: ☐ Receiving Party: ________________________________

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☐ Email: ________________________________

☐ **Eaton Rapids Medical Center Family Practice & Redicare**
1500 S Main Street, Eaton Rapids, MI 48827
Phone: (517) 999-4500 Fax: (517) 999-4510

☐ **Springport Medical Clinic**
400 E. Main St. Suite 200, Springport, MI 49284
Phone: (517) 857-4500 Fax: (517) 857-4510

Specific types of information to be disclosed (*include dates of treatment, check all that apply*):

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service or mental health records, communications made with a social worker and HIV/AIDs and AIDS-related complex information or documentation, if such information exists.

Dates of treatment to be included: __________ to __________ **OR** ☐ All past, present, and future periods.

☐ Clinic/Visit notes ☐ Discharge Summary ☐ Operative/Pathology report ☐ OB/GYN records
☐ Mental health ☐ HIV/HIDS and AIDs ☐ Drug and/or alcohol treatment
☐ Emergency Department record ☐ Diagnostic testing (lab, x-ray, cardio) ________________
☐ Other: ____

Purpose and need for disclosure:

☐ Continuing care ☐ Insurance billing ☐ Disability ☐ Marketing
☐ Personal use ☐ Fundraising activities ☐ Application for employment
☐ Enrollment in a health plan ☐ Other: ____________________________

- *I understand that I may revoke this authorization at any time by sending a written revocation to Eaton Rapids Medical Center Family Practice/Springport Medical Center except to the extent that Eaton Rapids Medical Center has taken action in reliance on the authorization.*
- *I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal or state law.*
- *I understand that my continued or future treatment by Eaton Rapids Medical Center Family Practice/Springport Medical Center is not conditional upon my providing or signing this authorization unless this authorization is providing data in connection with medical or clinical trial research.*
- *I understand that if Eaton Rapids Medical Center Family Practice/Springport Medical Center is the receiving party, I have the right to inspect or copy the health information Eaton Rapids Medical Center Family Practice/Springport Medical Center intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.*
- *I further understand that correspondence and records from other health care providers will not be released with this routine request.*
- *Please be aware that there may be processing fees charged for multiple requests for the same information. There is no charge to send directly to another physician.*
- *This authorization is made in accordance with federal and state law and is valid for a period of one year after being executed; however, it may be revoked by me at any time by providing written notice to the above-named party. A facsimile or photocopy of this document will be accepted in lieu of the original.*

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Patient Signature or Legal Guardian/Representative *Relationship to Patient* *Date*

Identified individual by: ☐Photo identification ☐Matching signature ☐Personally known

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Witness Signature *Witness Printed Name* *Date*