Authorization to Release Medical Information

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West Michigan Rehab & Pain Center

Patient Name: _____ Date of Birth: _____

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2. TO RELEASE TO:

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

3. **RECORDS FROM THE TIME PERIOD:** / / through / /

4. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports ☐ FCE/Disability Evaluation
☐ MRI ☐ CT ☐ EMG ☐ IME ☐ Other: _____

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and State Law MCL 333.6111-333.6113 and information about human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-Aids, and SIDS related complex-ACR, as defined by the Department of Public Health rules (1989 Public Act 174.) The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

6. I understand that this authorization will automatically expire in one year or once the purpose for which it was signed is accomplished. The Protected Health Information disclosed under this authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my Protected Health information.

7. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken. I acknowledge that West Michigan Rehab and Pain Center will use or disclose my Protected Health Information in reliance upon this authorization.

8. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. The requestor may be provided with a copy of this authorization.

9. By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use or disclosure of my Protected Health Information is in accordance with the terms of this authorization.

Patient's Signature: _____ Date: _____

If the patient is unable to sign for themselves or is a minor, please complete the following:

_____ _____ _____
Parent/Responsible Relative/Legal Guardian Signature Relationship Date

Signature of Witness: _____ Date: _____