WEST FRONT PRIMARY CARE

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Authorization for Use and Disclosure of Protected Health Information

I,_____, Date of birth: _____, authorize the disclosure of my protected health information. I understand that this authorization is voluntary and made to confirm my direction.

I Hereby Authorize:	**To Release My Records To:**
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

Purpose of Disclosure/Release: ❒ Continuation of Care ❒ Transition of Care ❒ Other:_____

Information To Be Released (please initial):

❒_____Entire medical record (this is most often for **New Patients only**)

❒_____Health care information relating to the following treatment condition(s):

- ❍ Most recent colonoscopy
- ❍ Most recent pap/HPV
- ❍ All abnormal results for:_____
- ❍ Radiology Report for:_____
- ❍ Office procedure notes with resulting pathology reports for:_____
- ❍ Other (please specify):_____

❒_____Health information in my record for: ❍ last one year ❍ last two years ❍ specific dates:_____

I specifically DECLINE the release of information relating to (please initial):

_____I decline release of Substance Abuse records (including alcohol, drug, and prescription medication)

_____I decline the release of Mental Health or Behavioral Health records

_____I decline the release of HIV/AIDS information

Code 42 of Federal Regulations of the HIPAA and Michigan, Dept. of Public Health Act (Public Act 174, 1989)

ACKNOWLEDGEMENT OF UNDERSTANDING: - By signing the completed form, I hereby certify that I am acknowledging my consent is given freely and voluntary. I am certifying that I understand the following:

- This authorization will expire 90 days from the date signed unless otherwise noted here_____.
- I may revoke this authorization at any time by notifying the providing organization in writing and it will be in effect upon the date of notification, unless the record transaction is already in action.
- The information used or disclosed following this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
- I understand that in accordance with Michigan law, I may be charged a fee for preparing and sending copies except for uses and disclosure for the purpose of treatment and operations. The fee will not exceed current state limits.

_____ _____ _____

Patient or Guardian Signature Date Patient Name and Relationship to Patient

Staff Int

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