LAKEWOOD FAMILY MEDICINE – 382 N. 120TH AVE. HOLLAND, MI 49424
MEDICAL RECORDS ~ AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Phone #:_____ Date of Birth: _____

I hereby authorize any and all treating physicians, institutions, nurses, psychologists, therapists, social workers, etc., to release information in my chart, as well as verbal information, to the individual or organization listed below.

****NOTE: We cannot request/send the records without a phone, fax and/or address of the doctor/facility****

1. Records are to be sent **TO:**

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone # for above facility: _____

Fax # for the above facility: _____

Records are to be sent **FROM:**

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone # for above facility: _____

Fax # for the above facility: _____

***PLEASE NOTE: A fee may occur with the request for records, this request may be processed by our 3rd party copy service ScanSTAT**

2. Information to be sent:

☐ Entire record

☐ Specific information: _____

The purpose for this disclosure:

Please Note: A fee may occur when requesting records

☐ Changing physicians
Reason for change: _____

☐ Specialist Services Only

☐ Other: _____

I UNDERSTAND that my records are protected under Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE INCLUDE: DIAGNOSIS, PROGNOSIS AND TREATMENT FOR PHYSICAL AND/OR EMOTIONAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR CHEMICAL DEPENDENCY; ALSO DIAGNOSIS, TESTING FOR AND/OR TREATMENT WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX (ARC).

There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by "HIPAA" Federal Health Insurance Portability and Accountability Act. However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

I UNDERSTAND that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid no longer than that reasonably necessary to effectuate the purpose for which it is given or until it expires 1 year from the date signed below or the conclusion of the litigation currently pending. I understand my signature below indicates I have read all information. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs authorization. **I HEREBY RELEASE any and all providers, THEIR EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY FILE.**

Photostatic copies of this authorization shall serve in its stead.

Signature: _____ Date: _____

Witness: _____ Date: _____

SPECIAL NOTE FOR MINORS: In Michigan, a minor has the authority to consent on his or her own behalf for alcohol or drug abuse treatment AND where he/she professes to be infected with VD or AIDS.

Updated 9/1/21