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PATIENT CONSENT FOR RELEASE OF INFORMATION

All parts of form must be completed before processing

Patient Name _____ **Date of Birth** _____

Patient address _____ **Phone Number** _____

I WOULD LIKE TO

- ☐ **RECEIVE a copy of my protected health information records at this practice. (Address above)**

OR

- ☐ **SEND a copy of my protected health information to**
  Dr's Name: _____
  Address: _____
  _____

NOTE: I recommend you ask your new physician what records they would like you to request. Most lab work and testing such as mammograms, x rays, stress tests, etc. are accessible through the hospital's electronic record and your new provider will not want paper copies. Consider requesting 2-5 years of Office Visit Notes.

FEES

(Per State of Michigan Medical Records Access Act Fee schedule)

Pages 1-20 @ $1.27 per page **Pages 21-50 @ .63 per page** **Pages 51+ @ .25 per page**

I agree to pay copying fees according to the State of Michigan Fee Schedule before mailing records.
Please notify me at Ph: _____ of the copying cost after computing the fee.

INFORMATION TO BE RELEASED

- ☐ **My complete record at the practice (includes Notes, Testing and Correspondence)**

OR

- ☐ **A specific section of my record for the indicated time period:**
  Office Visit Notes **from** _____ **through** _____
  Labs and testing results **from** _____ **through** _____
  Correspondence **from** _____ **through** _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I also understand that the health record I have authorized the release of may contain information which discloses that I have/had an HIV testing/infection, acquired immunodeficiency syndrome or acquired immunodeficiency related complex; nevertheless, I hereby authorize the release of such health record. This consent will expire one year from the date of which it is signed. The facility, its employees, and attending physician are released from legal responsibility for the release of the above information to the extent indicated and authorized herein. This practice has the right to deny access, in whole or in part, to protected health information as provided in sec 164 524 paragraph a sections 2 and 3 of the Healthcare Portability and Accountability Act of 1996

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____