CRYSTAL LAKE HEALTH CENTER

WWW.crystallakeclinic.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient/Client Name	Date of Birth
Address (street, city, state, zip)	
Phone Number (please include an alternate phone number too)	

I Hereby Authorize:	**To Release To:**
Provider: _____	**Provider:** _____
Phone: _____	**Phone:** _____
Fax:	**Fax:**

I authorize its Director or designee, or Medical Record Department, to release information contained in my patient records to the individuals or organizations listed above, only under the conditions listed below:

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist, and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and IADS-related complex (ARC).

Specific Information to Be Disclosed

☐ Progress Notes	☐ History and Physical	☐ Lab Reports	☐ EKG
☐ X-ray Reports	☐ Pathology Report	☐ Operative Report	☐ Complete chart
☐ Records relating to a specific problem:			

Purpose and Need for Such Disclosure – A sufficient purpose may be "Personal Use"

☐ Continuation of Care	☐ Insurance/Worker's Comp	☐ Personal Use
☐ Legal/Attorney	☐ Disability	☐ Other:

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I understand that my medical record may contain reports, test results and notes that only a care provider can interpret.

I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I will not hold Crystal lake Clinic liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.

I understand that failure to provide all information requested may invalidate this authorization.

I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

This authorization is subject to a written revocation at any time except in those circumstances in which the Clinic has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire one year from the date of signing, if not otherwise designated ("none" may be specified).

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

Date:_____Event:_____Condition:_____

This authorization must be dated subsequent to the visits that you are requesting

Signature	Date	Witness	Date

Relationship to Patient _____

☐ If patient is a minor or incapable of signing, a copy of the appropriate legal documentation is attached, if applicable.

Driver's License/Identification Verified, As Applicable