

**HIPPA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

**I Authorize:** \_\_\_\_\_

To release my health care information to: **Michigan-Wisconsin Family Practice Associates, P.C.**

Circle: **Beth Schroeder, M.D. / Katie Brown, P.A. / Heather Hayes, P.A. / Karen Steber, FNP / Kristi Olson, M.D.**

**Information to be Release:**

**Dates of Treatment:**

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ All Dates

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Specific Dates: \_\_\_\_\_

**Purpose of Disclosure :** \_\_\_\_\_ Transfer of Care/Continuation of Care

\_\_\_\_\_ Attorney/Legal

\_\_\_\_\_ Insurance/Workman's Compensation

\_\_\_\_\_ Other \_\_\_\_\_

**FEES FOR COPIES:** Federal and State laws permit a fee to be charged for the copying and mailing of patient records. If a fee applies, you may be required to pre-pay for the copies or your copies will be mailed along with and invoice.

I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may write a letter to the facility/Provider.

I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness