AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ SSN: _____

Date of Birth: _____ Telephone #: ( ) _____

I, _____ , hereby authorize the release of my medical information
patients name (please print)

FROM: (indicate one or more)

( ) Bay View Obstetrics & Gynecology
560 W. Mitchell St., Suite 210
Petoskey, MI 49770

( ) Other _____
_____
_____

Including (if any):

- alcohol and drug abuse records protected under the regulation in 42 Code of Federal Regulation, Part 2.
- psychiatric / psychological services records, social work records.
- Any information regarding serious communicable diseases and infections as defined by Michigan Department of Public Health Code (Act 368 of 1978 as revised), which includes venereal disease, tuberculosis, HIV, AIDS or ARC.

MY INFORMATION MAY BE RELEASED TO THE INDIVIDUALS OR ORGANIZATIONS LISTED BELOW, ONLY UNDER THE CONDITIONS LISTED BELOW.

( ) Bay View Obstetrics & Gynecology
560 W. Mitchell St., Suite 210
Petoskey, MI 49770
Fax: 231-487-2115
Phone: 231-487-2340

( ) Other _____
_____
_____
_____

Specific type of information to be disclosed and dates of service:

_____ Any information related to my care for _____
_____ Progress Notes _____
_____ X-ray / Lab Reports _____
_____ Referral Physician or Hospital Reports _____
_____ Other

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. If not previously revoked, this authorization expires 12 months from date of signature.

Signature of Patient / Authorized Representative: _____ Date: _____

Signature of Witness (if required): _____ Date: _____