Great Lakes Bay Health Centers

Great Lakes Bay Health Centers
Health Information Management Department
501 Lapeer Avenue, Saginaw MI 48607
Telephone: (989) 759-6480 Fax: (989) 755-3603

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____

LAST NAME, FIRST NAME M.I BIRTHDATE LAST 4 DIGITS OF SS #

Please check box that applies:

I authorize GLBHC: ☐ ***To release information to:*** ☐ ***To request information from:***

_____

Name of Facility/Individual

PLEASE NOTE YOUR RECORD PREFERENCES:

- ☐ Release Records (Please send a copy of my medical records to party above ASAP.)
- ☐ Ongoing Release (Please keep this form on file for future releases, but do not send a copy of my medical records immediately.)
- ☐ Records on Paper *(Please note: if not specified, records will be released in paper form)*
- ☐ Records sent electronically – circle one: secure e-mail through the patient portal

INFORMATION TO BE RELEASED:

- ☐ All medical records
- ☐ Specific medical records only:_____
- ☐ Other (e.g., billing records, X-rays, Dental records, WIC Records): _____

DATES OF SERVICE FROM: _____ TO: _____

PURPOSE OF REQUEST: ___ Continuation of care ___Personal Use ___ Other

I understand that:

I understand that the specific type of information disclosed may include, if applicable, any diagnoses, prognosis and/or treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or sexually transmitted diseases.

I understand that I have the right to revoke this consent at any time, unless the disclosing facility has already released the information on reliance of my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing the data. If no revocation is sent, this authorization will be valid for (60) days from the date signed below.

I understand that the information may no longer be covered under the Privacy Rule, once the designated party has received it. I acknowledge the potential for re-disclosure. I understand that Great Lakes Bay Health Centers cannot be held responsible for any re-disclosure of protected health information.

I understand that I will not be denied treatment, payment, enrollment or eligibility for benefits based on signing this release of information.

I understand that there will be a charge of $10.00 per chart for copies of records for my own personal use.

_____ _____

(Patient Signature and/or Parent/Guardian/Legal Representative) (Date)

_____ _____

(Witness Signature) (Date)

OFFICE USE ONLY

Date Rcv'd: _____

Date Completed: _____

Initials:

Form# M117
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