East Paris Internal Medicine Associates, P.C.
1000 EAST PARIS AVENUE, S.E. SUITE 260
GRAND RAPIDS, MI 49546
TELEPHONE: 616-957-9237
FAX: 616-957-1013

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____Date of Birth: ___/____/_____
Maiden Name: _____

Request Records From: _____
Address: _____
_____
Phone Number: _____Fax Number: _____

Send Records To: _____
Address: _____
_____
Phone Number: _____Fax Number: _____

PURPOSE OF DISCLOSURE

☐ Attorney/Legal ☐ Continued Patient Care ☐ Insurance ☐ Personal Use

☐ Worker's Compensation ☐ Transfer to new PCP Dr:_____ ☐ Other _____

I authorize the release of health information, contained in my medical records including:

- Information regarding communicable disease and infections, as defined by statute and Michigan Department of Health rules, which include venereal disease. Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus (HIV), HIV Testing
- Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), and _____(specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist

Medical Information to be sent:

☐ Pertinent medical records only from the past **two (2) years,** or as determined by the physician

☐ Office notes ☐ Lab results ☐ X-rays ☐ Colonoscopy

☐ Mammogram ☐ Other _____

I understand the practice places no condition to sign this authorization on the delivery of healthcare or treatment

I hereby authorize medical information to be released as indicated above. I understand that this release is effective for 1 year from the date of execution, but that I may revoke my consent at any time by providing a written request to do so to East Paris Internal Medicine Associates, P.C.

Redisclosure: We have no control over entities or person(s) you have listed to received your protected health information (HPI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

_____ _____
Signature of Patient or Patient's Legal Guardian Date

*Payment: There may be a fee associated with this record request. Payment may be required to be paid in full prior to releasing the records