Grand Rapids Hand PLC.

Authorization for Release of Medical Record Information

Patient Name: ________________________________ Date of Birth: ___________________________

Phone: H) ____________________________________ Phone: W) _____________________________

Address: _____________________________________ City/State/Zip: __________________________

Please Note: Copy Fee of $20 May Be Charged for Medical Records

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Above listed patient authorized the following healthcare facility to make record disclosure:

Grand Rapids Hand PLC, 4215 Michigan St NE, Grand Rapids, MI 49525

Date and Type of Information to Disclose (check below)

______ 2 years prior from date last seen

______Dates other: __________________________

the purpose of disclosure is:

____Change of Insurance or Physician

____Continuation of Care

____Referral

____Other________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ____

Address: ____

City, State, and Zip: ____

Fax: ___________________________ Phone: _______________________________

Choose One: _____ Please Mail _____Please Fax

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

X____ ____________________________________

Signature of Patient/Parent/Guardian or Authorized Representative **Date**

Guardian or Authorized Representative must attach documentation of such status

____ ____________________________________

Printed name of Authorized Representative Relationship / Capacity to patient

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Address and telephone number of Authorized Representative