
Authorization for Release of Medical Information to Hastings Internal and Family Medicine

Patient Name _____ Date of Birth _____ Today's Date _____

I authorize _____

Name of Practice or Individual

Address

Telephone Number _____ Fax Number _____

to disclose or provide the following protected health information about me to:

Hastings Internal and Family Medicine
225 S M-37, Suite 1
Hastings, MI 49085
Fax 269-948-0099

Entire patient record; (or, check only those items of the record to be disclosed below)

- | | |
|--|---|
| <input type="checkbox"/> Office/Consult notes | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Lab/X-ray results, pathology reports, | <input type="checkbox"/> Medical Summary |
| <input type="checkbox"/> Financial History | <input type="checkbox"/> Confidential record of HIV and communicable disease testing |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Confidential records of mental health or substance abuse treatment |

Only the following: _____

Dates: _____

- Purpose for release:
- Transfer of care
 - Continuing care or consultation
 - Request of patient or legal representative

- This release is effective for one year from the date of signature. It may be revoked at any time by providing written notice to the practice or individual listed above.
- A facsimile or photocopy of this document may be accepted in lieu of the original.
- Medical records released to Hastings Internal and Family Medicine are subject to privacy protections under the Health Insurance Accountability and Portability act, and may not be further released without specific written authorization.

Signature of Patient or Legal Representative _____ Relationship to patient if applicable _____ Date _____

Signature of Witness _____ Date _____