Upper Great Lakes Family Health Center

301 Explorer Street
Gwinn, MI 49841
Tel. (906) 372-3241
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INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

(Patient Name) (Date of Birth) (Maiden/Previous Name)

(Street Address) (City) (State) (Zip Code)

(Patient Telephone Number) (Patient Fax Number, if applicable)

RELEASE RECORDS FROM:

Address:

Phone/Fax:

RELEASE RECORDS TO:

Address:

Phone/Fax:

INFORMATION TO BE RELEASED:

Dates of Service: _____

☐ All Clinic Records ☐ Lab Reports ☐ Dental Records ☐ X-Ray Reports ☐ Immunization Record

☐ Operative Reports ☐ Other (please specify) _____

The undersigned herby authorizes the physician to provide the above named persons with a copy of any and all records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to treatment of patient described above except as indicated below. It is understood that the copy of the records will be provided to the designated company or individual only upon payment of a reasonable charge for reproduction of the records.

THE PURPOSE OF THIS REQUEST IS FOR (PLEASE CHECK ALL THAT APPLY):

☐ Further Medical Care ☐ Insurance ☐ Disability ☐ Worker's Comp ☐ Relocating ☐ Personal Use

☐ Other: _____

This authorization shall be considered invalid after one (1) year from the date of signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke the authorization retroactively for information already released. In furtherance of this authorization, I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

(Patient Signature or Parent/Legal Authorized Representative) (Date)