Upper Great Lakes Family Health Center

301 Explorer Street
Gwinn, MI 49841
Phone: (906) 346-3241 | Fax: (906) 372-3230

Patient Authorization for Disclosure of Health Information

(Patient Name) _____ (Date of Birth) _____ (Maiden/Previous Name) _____ (Patient Phone #) _____

Records to Be Disclosed From:	**Disclose Records To:**
Organization: _____	Organization: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Covering the Period of Healthcare from:

Date(s): _____ to _____

OR ☐ All Past/Present Health Information

Information to Be Disclosed:

- ☐ Entire Health Record
- ☐ Medical Progress Note(s)
- ☐ Immunization Record
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Dental Record(s)
- ☐ Dental Imaging
- ☐ Billing Record(s)
- ☐ Other: _____

Purpose of Disclosure (check all that apply)

- ☐ At the Request of Patient
- ☐ Continued Care
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Worker's Comp
- ☐ Relocating
- ☐ Personal Use
- ☐ Other: _____

Disclosure Format

- ☐ Fax
- ☐ Electronic (Patient Portal)
- ☐ Paper-Pickup in Person
- ☐ Paper-US Mail
- ☐ Other: _____

State and federal law protect the following information. If this information applies to you, please initial if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Use Records	Initials:	_____	Dates:	_____
HIV Testing and Results	Initials:	_____	Dates:	_____
Behavioral Health	Initials:	_____	Dates:	_____
Psychotherapy Records	Initials:	_____	Dates:	_____
Genetic Testing Results	Initials:	_____	Dates:	_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 301 Explorer Street, Gwinn, MI 49841. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules

(Patient or Authorized Representative Signature) _____ (Date) _____

Print Name _____ Relationship to Patient (if applicable) _____

(For Office Use Only): Received On: _____ *Verified By:* _____