AUTHORIZATION FOR COMPLETION OF FORMS

PLEASE NOTE: All numbered items must be completed to process your form. There could be a charge for completion of your form.

Patient Name: _____ Phone#: _____ Date of Birth: _____

I hereby authorize any and all treating physicians, institutions, nurses, psychologists, therapists, social workers, etc., to release information in my chart as well as verbal information, to the individual or organization listed below:

1. Records are to be sent **TO**:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Records are to be sent **FROM**:

Name: Lakewood Family Medicine

Address: 382 N. 120th Avenue

City: Holland State: MI Zip: 49424

2. Primary Care Physician: _____

3. Upon completion of form ☐ Call ☐ Mail ☐ Fax _____

If your form is for disability or due to being off work continually or as needed, please complete below as well in order to process form:

4. Dates off work: **FROM:** _____ **TO:** _____ **RETURN TO WORK:** _____

Mark box if time off is only as needed for chronic condition:

5. Reason off work (diagnosis): _____

6. Fee: For 1 form **$15** For 2 forms **$20** For 3 or more forms **$25** Paid _____ Due _____

Specific type of information to be disclosed: Any and all records concerning your treatment, care, evaluation, counseling, therapy and or medical provider service of any kind rendered including evaluation, and/or treatment, recorded notes of any kind, computer entered notes, medical records obtained from other providers, correspondence, laboratory study results, x-ray reports, and any other written information of any kind contained within the medical file pertaining to this patient.

Information to be sent:

- Any and all information or records needed to complete form(s). This includes verbal discussions between entities.

The purpose for this disclosure:

- Form(s) completion, and/or further information requested.

I UNDERSTAND that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE INCLUDE: DIAGNOSIS, PROGNOSIS AND TREATMENT FOR PHYSICAL AND/OR EMOTIONAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR CHEMICAL DEPENDENCY; ALSO DIAGNOSIS, TESTING FOR AND/OR TREATMENT WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX (ARC).

I UNDERSTAND that I have the right to revoke this consent at any time unless the facility which is to make the disclosure of information has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid no longer than that reasonably necessary to effectuate the purpose for which it is given or until it expires 1 year from the date signed below or the conclusion of the litigation currently pending. I understand my signature below indicates I have read all information.

I HEREBY RELEASE any and all providers, THEIR EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY FILE.

Photostatic copies of this authorization shall serve in its stead.

Every attempt will be made to have your form completed within 5 business days from the date below

Signature: _____ Date: _____

Witness: _____ Date: _____

SPECIAL NOTE FOR MINORS: In Michigan, a minor has the authority to consent on his or her own behalf for alcohol or drug abuse treatment AND where he/she professes to be infected with VD or AIDS.

Updated 1/2010