LAKEWOOD FAMILY MEDICINE – 382 N. 120TH AVE. HOLLAND, MI 49424
MEDICAL RECORDS ~ AUTHORIZATION FOR RELEASE OF INFORMATION

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.

****NOTE: We can not request/send the records with out a phone, fax and/or address of the doctor/facility****

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

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone # for above facility: _____

Fax # for the above facility: _____

Records are to be sent **FROM:**

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone # for above facility: _____

Fax # for the above facility: _____

Please send records to LFM in a CD format if available

2. Information to be sent:

☐ Entire record

☐ Specific information: _____

The purpose for this disclosure:

Please Note: There is a $25 fee for transferring records out of our office, this is due before process can begin

☐ Changing physicians
Reason for change: _____

☐ Specialist Services Only

☐ Other: _____

Specific type of information to be disclosed: Any and all records that are requested above 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, all forms including work generated such as FMLA and disability, and any other written information of any kind contained within the medical file pertaining to this patient.

I UNDERSTAND that my records are protected under 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 INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE 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.

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