



## AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_  
Phone: \_\_\_\_\_

I authorize and request \_\_\_\_\_ to release information contained in my patient records, including as applicable: alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of the Code of Federal Regulations Part II.; information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS-related complex (ARC), as defined by the Department of Public Health rules (1989 Public Act 174).

Specific type of information to be disclosed:

- |   |   |
|---|---|
| <input type="checkbox"/> Dates of treatment _____       | <input type="checkbox"/> Emergency Room Reports |
| <input type="checkbox"/> Complete Copy of Medical Chart | <input type="checkbox"/> Consultation Reports   |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Laboratory Reports     |
| <input type="checkbox"/> History and Physical           | <input type="checkbox"/> Radiology Reports      |
| <input type="checkbox"/> Operative Report               | <input type="checkbox"/> Other: _____           |

Name and address of receiving party or agency:

GENESIS FAMILY HEALTH CENTER, PLC  
3916 STONEGATE PARK  
ST. JOSEPH, MICHIGAN 49085

Purpose and need for such disclosure:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Patient Request | <input type="checkbox"/> Attorney Request | <input type="checkbox"/> Insurance Audit |
| <input type="checkbox"/> Continues Care  | <input type="checkbox"/> Court Request    | <input type="checkbox"/> _____           |

I understand that this authorization will automatically expire when the purpose for which it was signed is accomplished. I also understand that I may revoke this authorization in writing at any time, unless some action has been taken by the Genesis Family Health Center, PLC based on this consent. Without my expressed written revocation, this consent will expire 180 days from the date of signature below.

I have read the above and acknowledge that I fully understand the terms and conditions of this authorization.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date