HAND SURGERY OF NORTHERN MICHIGAN
701 W. FRONT ST, STE 100
TRAVERSE CITY, MI 49684
(231)935-0800, fax (231)935-0808

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Date of Request: _____ Phone #: _____

☐ **INFORMATION IS NOT TO BE RELEASED TO** _____

☐ I authorize Hand Surgery of Northern Michigan **to release information to:**

☐ I authorize Hand Surgery of Northern Michigan **to obtain information from:**

Name of Spouse, Family Member, Provider, Facility: _____

Address: _____

City/State/Zip Code: _____

Phone #/Fax # (include area codes): _____ / _____

Specific information to be disclosed: ☐ Treatment Summary ☐ Entire medical record, as allowed by law

☐ Other specific dates/injury: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- If the person/facility receiving this information is not a health care/medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- PHI released may include records generated by another healthcare provider or facility.
- This authorization is voluntary and will remain in effect until notifying the providing organization in writing, except where a disclosure has already been made in reliance on my prior authorization.
- Records may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, social services records, if any, mental health records, if any, including communications made by me to a social worker or mental health professional, and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) Test, Acquired Immunodeficiency Syndrome (AIDS), and Aids-related Complex (ARC), if any, to the individuals above.

Signature of Patient: _____ Date: _____

Signature of Parent of Minor/Patient Representative: _____

Date: _____ Relationship to Patient: _____