

grand traverse children's clinic



GTCChildrens.com

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This form is to be used by patient's, 18 years of age and older, who are giving us permission to speak with their parent(s) or other individual regarding their medical history and or current records

Patient's Name: _____ DOB: _____

Address _____

Phone Number: _____ Alternate: _____

Whom may we speak with regarding your medical history/records?

Mother (list full name): _____

Father (list full name): _____

Other (list full name & relation): _____

What information may we share with the list individuals?

_____ Entire medical record (this includes allowing them to schedule appointments for you, request refills on your medications, obtain test results, speak with the nurse/doctor regarding your entire medical record, etc.)

_____ Specific Dates: _____ to _____

_____ Information you **DO NOT** want released: _____

*I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or Aids Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral &/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2). Any information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient and is therefore no longer protected by the federal privacy regulations. **This authorization will expire upon written revocation.***

*I authorize and request any and all of my medical information, as indicated above, to be released according to the terms outlined in this agreement. Additionally, **I certify that I am the patient and am over the age of 18** at the time of this authorization. My signature (below) confirms that the above statements are true and were made in good faith. I agree to defend, indemnify and hold Grand Traverse Children's Clinic, PC (as well as its employees) harmless from any claims and expenses, including attorney's fees, potentially arising from my actions related to same.*

Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____