

GRAND RAPIDS WOMEN'S HEALTH

555 MidTowne NE, Grand Rapids, MI 49503

Obstetric & Gynecology Specialists
Phone: (616)588-1200 • Fax: (616)588-1250

Female Pelvic Medicine & Urogynecology Institute of Michigan
Phone: (616)588-1800 • Fax: (616)588-1850

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Birth date: _____

Address: _____ Phone: _____

Every section of this form must be completed in order for this Authorization to be valid.

1. List specific information being requested (e.g. related to a specific condition or time frame):

All Clinical Medical Records

Other Records- _____

2. Records/Information from:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

3. Send information to:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

4. Reason for the Request: Continuing patient care

Transferring out of office, please list reason: _____

Other: . _____

5. This Authorization will expire one year from the date this form is signed if no date or event is listed.

Expiration Date or Event: _____

As long as I am a patient

I understand that there may be a fee to cover the costs of sending my medical records.

I understand that the information being used or disclosed may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS and ARC. I also understand that I have the right to revoke this Authorization in writing or by completing a Revocation of Authorization Form.

I further understand that the PHI that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my PHI. In addition, Grand Rapids Women's Health will not condition treatment if this Authorization is not signed, except if: 1) the treatment is related to research, or 2) the provision of health care is solely for the purpose of creating PHI so it can be disclosed to a third party.

By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my PHI in accordance with the terms of this Authorization.

Signature of Patient or Authorized Representative

Date

Name/Relationship of Authorized Representative's authority to sign for the patient