

Date of Request: _____

Scheduled Appointment: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

Name _____ Date of Birth _____
Last First Middle

Other names used (if applicable) _____

Address _____

City _____ State _____ Zip _____ Phone _____

I hereby authorize the protected health information regarding the above named person be forwarded:

Release (check one) <input type="checkbox"/> To <input type="checkbox"/> From	Release (check one) <input type="checkbox"/> To <input type="checkbox"/> From
Southwestern Medical Clinic Address _____ _____ City/State/Zip _____ Phone _____ Fax _____	Person/Institution _____ Address _____ _____ City/State/Zip _____ Phone _____ Fax _____

Type of Information Requested

All records (see following statement regarding complete record)

Limited records, include only the following:

I understand that if my record contains items related to mental health (anxiety or depression), alcohol or drug usage (including tobacco), testing for sexually transmitted diseases, HIV or AIDS, it will be included as part of your request. These items will only be excluded if requested, in writing, on this form.

- Purpose of disclosure:**
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Changing Doctors | <input type="checkbox"/> Changing insurance | <input type="checkbox"/> Worker's Comp |
| <input type="checkbox"/> Insurance Co. | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Research Study | <input type="checkbox"/> To speak with SWMC staff |
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Other _____ | | |

This authorization shall be in force and effect until: (check one of the following)

- Date _____
- The happening of the following expiration event: _____
- End of research study
- Completion of this request.

I understand that, as set forth in Southwestern Medical Clinic's Notice of Privacy Practices, I have the right to revoke this authorization at any time by sending written notification to:

Southwestern Medical Clinic
8008 M-139
Berrien Springs, MI 49103
Attn: Privacy Officer

See reverse side to complete form

For SWMC office use only

Copied _____ Faxed _____ Mailed _____ Picked Up _____
 (Date and initial all items that apply)

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Check one of the following:

- I understand that Southwestern Medical Clinic will not withhold treatment from me if I do not sign this authorization form.
- I understand that the service(s) provided by Southwestern Medical Clinic is solely for the purpose of creating a protected medical record for (insert third party here, i.e. employer) _____ and that my authorization is necessary to receive this treatment. I understand that if I do not sign this authorization, Southwestern Clinic will not provide health care services to me for the third party.
- I understand that the treatment being provided is related to research and that my authorization to release information for research-related purposes is helpful for treatment.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

(Provide a copy of this authorization to the patient if SWMC is requesting this authorization for our own use.)