Records Release Authorization

I, _____ hereby authorize Grand Traverse Internal and Family Medicine P.C., its Director or designee, to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, social services records, if any, and psychological services records, if any, including communications made by me to a social worker or psychologist, if any, and all information defined by statute and Michigan Department of Public Health Rules (Public Act, 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

TO: _____ Attention:_____
(Name of Person(s) or Organization to Whom Disclosure is to be Made)

_____
Address *City* *State* *ZIP*

Purpose and Need for Disclosure:

____ Continuation of Care ____ Disability Determination

____ Vocational Rehabilitation ____ Social Service Referral

____ Insurance/Billing Verification ____ Legal Follow-up

____ School ____ Other: _____

- I understand that my medical record may contain reports, test results and notes that only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.
- I will not hold Grand Traverse Internists liable for any misinterpretation of the information in my medical record as a result of not having consulted my physician for the correct interpretation.
- Without expressed written revocation this authorization will automatically expire one year from date of signing, or earlier upon written revocation.

Signature: _____ Date: _____

Relationship to Patient: _____ (if patient incapable of signing release)

Witness: _____ Date: _____

Patient Date of Birth: _____ Address: _____

City State, ZIP: _____ Telephone: _____