Grand Valley Health
Family Health Centers

# Authorization for Release of Medical Information

Please send requested information to the Family Practice checked below:

____ Beckwith Family Practice, 2680 Leonard NE, Grand Rapids, MI 49505 (616) 224-1515

**Please complete all areas marked with *. Failure to do so will delay release of your medical records.**

**Request for Records:**
I hereby request_____
*(Name and Address of Physician/Organization)
to release the medical records of the person listed below:

_____

*(Full Name of Patient) *(Date of Birth) * (Daytime Phone)

_____

* (Street Address) * (City/State) * (Zip Code)

**Release Records To:**_____
* (Name of Physician/Organization)

_____

* (Street Address) * (City/State) * (Zip Code)

**Reason for Release: (Optional)** _____

***Information to be released for last 3 years of GVFHC records:**

___ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

___Record of care from _____to _____ *INCLUDING* information related to the treatment for alcohol and/or substance abuse or dependency; behavioral or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS. There is a fee for records over 3 years.

By signing this form I understand the following:

- My information may be shared among each person and/or agency listed above.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information already shared based on my consent cannot be taken back.
- I should tell all people and/or agencies listed on this form when I withdraw my consent.
- I can have a copy of this form.

I understand that there may be a reasonable fee to cover obtaining and/or copying of the medical record, or any part of the medical record and that the fee must be paid in full prior to my obtaining any such copies. I understand that this authorization may be revoked by me (the patient or representative) at any time, except to the extent that the information described above has already been released. This consent expires one year from the date on which it is signed unless my consent is withdrawn or an earlier date of expiration is requested. I understand that my health care provider may not condition treatment on my signing this Authorization. I understand that if the recipient is not a health care provider, the records will no longer be protected by federal privacy laws and may be re-disclosed to others.

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I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

_____/ _____ _____

*Patient's (or Legal Representative's) Signature/Relationship to patient *Date

_____ _____

*Witness' Signature *Date

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## WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

**I withdraw my consent to the sharing of my health information:**

☐ Between any of the following persons or agencies:

_____ _____

_____ _____

_____ _____

**-OR-**

☐ For all person and agencies

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Signature of person withdrawing consent or legal representative Date

Relationship to Individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

**Verbal Withdraw of Consent:**

This consent was verbally withdrawn.

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Signature of person receiving verbal withdraw of consent Date