PATIENT NAME: _____ **DATE OF BIRTH**: _____

ADDRESS (Street, City, State, Zip): _____

NORTHWESTERN MICHIGAN DERMATOLOGY, PC

I hereby authorize: **Northwestern Michigan Dermatology, PC**

its Director of designee, or Medical Record Department to release information contained in my patient records to the individuals or organizations listed below, only under the circumstances listed below:

Information to be released to: _____
(Name of person(s) to whom disclosure is to be made)

_____
(Address, City, State, Zip)

Relationship of this person/organization to me (example: Primary Care Provider):_____

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Park 2, and the Health Insurance Portability and Accountability act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist 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).

PLEASE FORWARD THE FOLLOWING:

☐ History & Physical Examination	☐ Progress Reports	☐ Operative/Procedures Report
☐ Assessment	☐ Diagnostic Test Results	☐ Entire Chart
☐ Communication Exchange	☐ Treatment Plan	☐ Last 5 years (Transfer of Care)
☐ Psychosocial	☐ Billing Information	☐ Other:_____

REASON FOR REQUEST:

☐ Continuation of Care	☐ Social Service Referral	☐ Personal Use
☐ Vocational Rehabilitation	☐ Legal Follow-up	☐ Other:
☐ Insurance/Billing Verification	☐ Care Conference	_____
☐ School	☐ Referral Follow-up	_____
☐ Disability Determination	☐ Return to Work	

AUTHORIZATION FOR RELEASE OF INFORMATION:

- I understand that my medical record may contain reports and notes that only a care provider can interpret.
- I understand and have been advised that I should contact my care provider 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 Northwestern Michigan Dermatology PC liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- I understand that failure to provide all information requested may invalidate this authorization.
- I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form.

- I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

This authorization is subject to a written revocation at any time except in those circumstances in which Northwestern Michigan Dermatology PC has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire one year from the date of signing, if not otherwise designated ("none" may be specified).

REVOCATION (OPTIONAL): This authorization is revoked for the following specific dates, events, or conditions:

Date: _____ Event: _____ Condition: _____

(This authorization must be dated subsequent to the treatment you are requesting except in cases of ongoing treatments.)

SIGNATURE:

Signature: _____ Time/Date:_____

Witness:_____ Time/Date:_____

Relationship to Patient _____

☐ If patient is a minor or incapable of signing, a copy of the appropriate legal documentation is attached, if applicable.

☐ Driver's License/Identification verified, as applicable