

DayOne Family Healthcare, P.C.
363 Fremont Street, Suite 203
Battle Creek, MI 49017
PH: (269) 969-6123 FAX: (269) 969-6122

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

PATIENT FULL NAME _____

DATE OF BIRTH _____ SS# _____

I HEREBY AUTHORIZE:

(Practice Name and Address)

TO RELEASE MEDICAL INFORMATION TO:

(Practice Name and Address)

INFORMATION TO BE RELEASED

(PLEASE INITIAL APPROPRIATE LINE): If transferring out of practice, there is a fee for records.

- _____ LAST YEAR OF ALL TESTING, THREE YEARS CORRESPONDENCE FROM SPECIALISTS,
IMMUNIZATION RECORDS, GROWTH CHARS (FOR CHILDREN UNDER 5)
- _____ MEDICAL INFORMATION RELATED TO HIV/AIDS INFECTION
- _____ ANY RECORD OF TREATMENT FOR DRUG AND/OR ALCOHOL DEPENDENCY OR ABUSE
- _____ ANY RECORD OF MENTAL HEALTH TREATMENT
- _____ ELECTRONIC COPY OF RECORDS
- _____ SPECIFICALLY, ONLY THE FOLLOWING _____

PURPOSE OF RELEASE: ___ TRANSFER CARE REASON FOR TRANSFER _____

___ **COORDINATION OF CARE** ___ **SHARED INFORMATION**
___ **REFERRAL** ___ **NO REASON GIVEN**

The practice will _____, or will not _____ receive payment or other remuneration from third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in relation to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing expect when the practice has already taken action upon this authorization. I acknowledge that I may receive a copy of this authorization. This release is effective for one (1) year from the date of signing.

Patient Signature or Parent/Legal Guardian

Dated

Witness

Relationship to Patient