AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
TO GREAT LAKES ORTHOPAEDIC CENTER, P.C.

1. Patient's Name:________________________________SSN:________________ DOB:________________
Previous names used:____
Address:____
Telephone:____________________________

2. I authorize ________________________________ to release or disclose health information of the above named individual or organization to Great Lakes Orthopaedic Center, P.C. (the "Receiving Party"). Address: 4045 West Royal Drive, Traverse City, Michigan 49684. Attn:______________________ (Great Lakes Orthopaedic Center Provider.

3. This authorization is made in accordance with the federal and state law and is valid for a period of six months after being signed or until ___________. Alternatively, this authorization shall expire if and when:____

4. I understand that I may revoke this authorization at any time by sending a written revocation to the office listed here. Name:____, Address:
____
except to the extent that they have already taken action in reliance on this authorization.

5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.

6. A description of the health information I authorize for use or disclosure is: ___my entire medical record, ___visit notes ___ other (please specify). ____
For Service Dates:____

7. RELEASE OF THE FOLLOWING INFORMATION REQUIRES SPECIAL CONSENT. PLEASE CHECK YES OR NO TO EACH ITEM.

Yes____No____ Medical records or health information regarding drug & alcohol treatment care.
Yes____No____ Medical records or health information regarding HIV &/or AIDS.
Yes____No____ Medical records or health information regarding treatment for care of a mental health problem.

8. I understand that if the custodian of my records listed in item #2 has received Protected Health Information from another source, and plans to release it under this authorization, that I have the right to inspect or copy the health information to be disclosed, pursuant to this authorization, and may, upon inspection, revoke this authorization.

9. I understand that I may charged copy & mailing costs for the Health Information being requested. I agree to pay copy & mailing costs for records & x-rays I am requesting. I understand that it is my responsibility to contact the custodian of records listed in item #2 to determine the amount of these fees. I have been provided with a copy of this authorization for my records.
_______________ (initials).

DATE:_________________

WITNESS:_________________________

WITNESS:_________________________

____
Patient's or Legal Guardian Signature

____
Relationship to patient if other than patient or legal guardian. Address and telephone # of Patient or legal guardian, attach documentation.

IMPORTANT: This authorization must be filled out in its entirety in order to be valid.