GREAT LAKES ORTHOPAEDIC CENTER
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. **Patient's Name:** _____
   Date of Birth: ____/____/____
   Address: _____
   Phone: _____

2. I authorize Great Lakes Orthopaedic Center to release or disclose health information of the above named individual to:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

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 Date ____/____/____.

4. I understand that I may revoke this authorization at any time by sending a written revocation to Great Lakes Orthopaedic Center, 4045 West Royal Drive, Traverse City, MI 496848965 except to the extent that Great Lakes Orthopaedic Center, has taken action in reliance on the 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:
___Office/Progress Notes Date Range ___/___/___ to ___/___/___
___Operative/Procedure Reports Date Range ___/___/___ to ___/___/___
___XRay Reports ___X-Ray Films Date Range___/___/___ to ___/___/___
___Other (please specify
_____
_____
_____

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

☐ Yes ☐ No Medical records or health information regarding drug & alcohol treatment care.

☐ Yes ☐ No Medical records of health information regarding HIV and/or AIDS.

☐ Yes ☐ No Medical records of health information regarding treatment for care of a mental health problem. (note: psychiatric or mental health records received from a provider outside of Great Lakes Orthopaedic Center can not be released or inspected under this authorization.)

8. I understand that my continued or future treatment by or payment to Great Lakes Orthopaedic Center is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.

9. I understand that if Great Lakes Orthopaedic Center 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 Great Lakes Orthopaedic Center intends to use or disclose, pursuant to this authorization, and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

DATE: ____/____/____

WITNESS:_____ _____
Patient's or Legal Guardian Signature

WITNESS:_____ _____
Relationship to patient if other than patient or legal guardian.

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