Phone (231) 935-8750 Fax (231) 935-8749

BAY AREA FAMILY CARE OF TC, PLC

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME	DATE OF BIRTH
ADDRESS (street, city, state, zip)	PHONE

I hereby authorize BAY AREA FAMILY CARE, PLC 906 BUSINESS PARK DR. TRAVERSE CITY, MI 49686
(HOSPITAL/PROVIDER/PROGRAM NAME AND ADDRESS)

its Director or designee, or Medical Record Department, to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; social services records, if any; and psychological services records, if any, including communications made by me to a social worker or psychologist, if any; 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), if any, to the individuals or organizations listed below, only under the conditions listed below:

Information to be released to: _____ Attention: _____
(NAME OF PERSON(S) OR ORGANIZATION(S) TO WHOM DISCLOSURE IS TO BE MADE)

_____
ADDRESS CITY STATE ZIP

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

DATES OF HOSPITALIZATIONS OR OUTPATIENT SERVICES:

_____ _____ _____ _____ _____ _____ _____

SPECIFIC INFORMATION TO BE DISCLOSED

- ☐ ENTIRE CHART
- ☐ COMMUNICATION EXCHANGE
- ☐ HISTORY & PHYSICAL EXAMINATION
- ☐ ASSESSMENT
- ☐ PSYCHOSOCIAL
- ☐ TREATMENT PLAN
- ☐ ADMISSION/DISCHARGE LETTERS
- ☐ PROGRESS REPORTS
- ☐ RECOVERY PLAN
- ☐ DISCHARGE SUMMARY
- ☐ FAMILY DAY INFORMATION
- ☐ PERTINENT INFORMATION (Specify) _____
- ☐ OTHER (Specify information e.g.: films) _____ _____

PURPOSE AND NEED FOR SUCH DISCLOSURE

- ☐ CONTINUATION OF CARE
- ☐ DISABILITY DETERMINATION
- ☐ VOCATION REHABILITATION
- ☐ INSURANCE/BILLING VERIFICATION
- ☐ SCHOOL
- ☐ SOCIAL SERVICE REFERRAL
- ☐ LEGAL FOLLOW-UP
- ☐ FAMILY DAY OR CARE CONFERENCE
- ☐ REFERRAL FOLLOW-UP
- ☐ VISITATION
- ☐ RETURN TO WORK
- ☐ OTHER: _____ _____ _____

I understand that my medical record may contain reports, test results 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 Bay Area Family Care 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.

This authorization is subject to a written revocation at any time except in those circumstances in which BAFC 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.

REVOCATION (optional) - This authorization is revoked for the following specified dates, events, or conditions.

Date:_____ Event:_____ Condition:_____

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

SIGNATURE	DATE	WITNESS	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