

BAY AREA FAMILY CARE OF TC, PLC

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME	DATE OF BIRTH
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ADDRESS (street, city, state, zip)	PHONE
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I hereby authorize _____
NAME ADDRESS CITY STATE ZIP

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: BAY AREA FAMILY CARE, PLC Attention: _____
(NAME OF PERSON(S) OR ORGANIZATION(S) TO WHOM DISCLOSURE IS TO BE MADE)

906 BUSINESS PARK DR TRAVERSE CITY, MI 49686
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

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

PURPOSE AND NEED FOR SUCH DISCLOSURE

- | | | |
|---|--|---|
| <input type="checkbox"/> CONTINUATION OF CARE | <input type="checkbox"/> SOCIAL SERVICE REFERRAL | <input type="checkbox"/> RETURN TO WORK |
| <input type="checkbox"/> DISABILITY DETERMINATION | <input type="checkbox"/> LEGAL FOLLOW-UP | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> VOCATION REHABILITATION | <input type="checkbox"/> FAMILY DAY OR CARE CONFERENCE | _____ |
| <input type="checkbox"/> INSURANCE/BILLING VERIFICATION | <input type="checkbox"/> REFERRAL FOLLOW-UP | _____ |
| <input type="checkbox"/> SCHOOL | <input type="checkbox"/> VISITATION | |

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.

REVOCAION (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
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RELATIONSHIP TO PATIENT	<input type="checkbox"/> IF PATIENT IS A MINOR OR INCAPABLE OF SIGNING, A COPY OF THE APPROPRIATE LEGAL DOCUMENTATION IS ATTACHED, IF APPLICABLE.
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DRIVER'S LICENSE / IDENTIFICATION VERIFIED, AS APPLICABLE