West Michigan
FAMILY MEDICINE
616-785-3883
1550 3 Mile Rd NW, Suite A
Grand Rapids, MI 49544
WestMichiganFamilyMedicine.com

Limited Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____

Address: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: **West Michigan Family Medicine, PC**
1550 3 Mile Rd NW, Suite A
Walker, MI 49544

Purpose of Request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me, to the individuals listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):
Individual/Entity Name: _____

Address: _____

Phone: _____ **Fax:** _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record, including but not limited to: office notes, lab results, x-rays, hospital, nursing home, home health, hospice, and other physicians records, record of HIV and communicable disease testing, record of mental health or substance abuse treatment, and financial history report (previous 3 years only)
☐ Office notes, labs, and x-rays only
☐ Only send the following: _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):
☐ Patient request
☐ Other (please specify): _____

Expirations or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list an earlier expiration date if less than a year: _____

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Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will not be the responsibility of the practice.

Fee: Your medical records are copied and mailed by Datavant. Datavant will bill you directly for this service. If you have questions regarding the charge, call 800-367-1500.

Patient Signature: _____ Printed Name:_____

Date: _____

Parent/Guardian Signature (if applicable):_____ Date: _____

Parent/Guardian Printed Name and Relationship: _____