

7.31 Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize HEALTHCARE MIDWEST, P.C. ("HCMW") to release or disclose my personal and health information, including records relating to general medical care, serious communicable diseases such as HIV or AIDS, substance abuse treatment, and mental health services (except psychotherapy notes, unless specified below) to:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Description Of Information to Be Released:

- Entire Medical Chart
- All Billing Records
- X-rays and Other Radiology Records
- Psychotherapy Notes (no other information may be released pursuant to this Authorization)
- Other (please specify) _____

Purpose of Disclosure:

The disclosure is made at the request of the individual unless another purpose is stated here (if the purpose is for marketing, please state whether any remuneration will be received by the Organization): _____

Expiration or Termination of Authorization: This Authorization is valid until _____ (please specify a date or event of expiration). You must submit a new authorization after the expiration date to continue the authorization.

Right to revoke or terminate: Except to the extent HCMW has taken action in reliance on this Authorization, you have the right to revoke or terminate this Authorization by submitting a written request to our Privacy Manager prior to the expiration date listed above. This can be done in person or by mailing a request to: **HealthCare Midwest, P.C. Attn: Privacy Manager, 4341 S. Westnedge Ave. Suite 2205, Kalamazoo, MI 49008.**

Re-disclosure: Once your health information is disclosed pursuant to this Authorization, it may be subject to further disclosure and may no longer be protected by state or federal law.

Fees: There may be a reasonable, cost-based fee for providing copies of records pursuant to this Authorization. Payment of any such fee is due prior to the delivery of the records.

I understand that the Organization cannot condition my treatment on whether I sign this Authorization, unless the treatment is being provided solely to create information to be provided to a third party.

I HAVE READ AND UNDERSTAND THIS FORM. I AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature of Patient or Patient's Personal Representative

Date

If you are signing as a Personal Representative of the Patient, describe your relationship to the Patient and the source of your authority to sign this form on the Patient's behalf:

INTERNAL USE ONLY

DATE AUTHORIZATION RECEIVED

DATE PROCESSED

STAFF INITIALS

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