David J. Smith M.D., P.C. dba

Family Medicine of Michigan

1035 Charlevoix Dr., Ste. 100, Grand Ledge, MI 48837

Phone: (517)627-2181 Fax: (517)622-1242

Authorization for Disclosure of Protected Health Information / Records Release
Including Confidential and Restricted Confidential Information

_____	_____	_____
Patient Name	Date of Birth	Social Security Number
_____	_____	____ _____
Street Address	City	State Zip Code
_____	_____	
Home Phone Number	Work Phone Number	

I authorize and request the described information to be disclosed under the following conditions:

1. Name of persons or organizations to disclose information:

   _____

2. Name of persons or organization to receive information and their specific address and phone number to receive the information at: _____
   _____
   _____

3. The purpose or need for such disclosure:
   - ❑ Transferring to new Primary Care Provider (Doctor's Office)
   - ❑ Personal Needs
   - ❑ Other: Specify _____

4. Specific "Confidential" information to be disclosed and time frame of information to be included:

   _____

5. If you do not wish any of the following "Restricted Confidential" information to be disclosed please check the box(s) below next to the item(s) you wish not disclosed as part of this request**. <u>If any of the below boxes are unchecked you are giving Family Medicine of Michigan additional specific consent to disclose the below information that we may keep about you.</u>**
   - ❑ Alcohol or drug abuse, or mental health treatment information under Title 42 of the Code of Federal Regulation Part II.
   - ❑ Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174 which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and hepatitis.
   - ❑ Records and reports sent to Family Medicine of Michigan from other health care providers, including hospitals and physicians.

6. Revocation of consent: This consent is subject to revocation at any time except to the extent action has been taken in reliance upon this consent. Any revocation of consent must be made in writing and delivered to this office at the above address.

7. This authorization is valid for **<u>your lifetime</u>** unless an alternative expiration date is provided below:

   _____.

_____	_____
Signature	Date
_____	_____
Witness	Date