Allegan Professional Health Services

AUTHORIZATION TO DISCLOSE OR REQUEST MEDICAL INFORMATION

**I give Allegan Professional Health Services permission *(CIRCLE) TO RELEASE TO OR TO OBTAIN FROM:***

Name/Agency: _____

Address: _____

Phone: (_____)_____--_____ Fax: (_____)_____--_____

**The medical records of:**

First Name: _____Middle Initial: _____Last Name: _____

Address:_____City:_____State:_____Zip:_____

Date of Birth: _____/_____/_____ Phone: (_____)_____--_____Phone: (_____)_____--_____

**Containing the following information (specify dates):** From:_____/_____/_____To:_____/_____/_____

☐Complete record ☐ Physician notes ☐ Lab results ☐ MRI scans ☐ X-ray reports

☐ Cardiac studies ☐Other (please specify) _____

**For the purpose of: (check one)** ☐*Cont'd Care* ☐*Transf. Care* ☐*Disability* ☐*FMLA* ☐*Legal* ☐*Personal* ☐*Other*

**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). Also, it may include information about behavioral or mental health services or treatment for alcohol or drug use.

**Re-disclosure:** I understand that any disclosure of information carries with it the potential for disclosure and that the information then may not be protected by federal confidentiality rules.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

**Other Rights**:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this for treatment. However, if this authorization is needed for participation in a research study my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (*If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)*

_____ _____

**Signature of Patient/ Legal Representative** **Date**

_____ _____

**If signed by Legal Representative Relationship to patient** **Staff initials**

**SEND RECORDS TO**:

| ☐ **Otsego Medical Center** | ☐ **Allegan Medical Clinic** | ☐ **Gobles Medical Clinic** | ☐ **Fennville Medical Center** |
|---|---|---|---|
| **900 Dix Street<br>Otsego, MI 49078** | **551 Linn Street<br>Allegan, MI 49010** | **406 N. State Street<br>Gobles, MI 49055** | **200 N. Maple Street<br>PO Box 1019<br>Fennville, MI 49408** |
| **PH: (269) 694-9640<br>FX: (269) 694-9648** | **PH: (269) 686-5800<br>FX: (269) 686-5899** | **PH: (269) 628-2196<br>FX: (269) 628-2363** | **PH: (269) 561-8761<br>FX: (269) 686-5438** |

**Complete this area only when requesting records for yourself**:

□ **picked up by me or my legal representative when ready (ID required) □ faxed to the above number given

□ **mailed to the above address given □ digital format (cd) □ via patient portal

**Please note a fee will be charged for paper records printed for patient in accordance with Public Act 47 of 2004, MCL § 333.26269