



# Medical Records Release

## Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

SSN (last four digits): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Who should release my information?

- Ob/Gyn Associates of Holland, 664 Michigan Avenue, Holland, MI 49423
- Other (Name/Address/Phone) \_\_\_\_\_

**Purpose of request (who will be authorized to receive information)** - I authorize the entity/individual identified above to disclose or provide protected health information, about me to the entity/individual(s) listed below.

### Who is authorized to receive my information?

- Ob/Gyn Associates of Holland, 664 Michigan Avenue, Holland, MI 49423
- Other (Name/Address/Phone/Fax) \_\_\_\_\_
- Email\* \_\_\_\_\_

\* Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

**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; **or**, check **only** those items of the record to be disclosed:
  - office notes
  - nursing home, home health, hospice, and other physician records
  - lab results, pathology reports
  - record of HIV and communicable disease testing
  - x-rays;
  - record of mental health or substance abuse treatment
  - financial history report (previous 3 years only).
  - Only send the following: \_\_\_\_\_

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

- Patient Request  Other \_\_\_\_\_
- I am transferring my care to:(PLEASE SPECIFY PHYSICIAN) \_\_\_\_\_

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: \_\_\_\_\_
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

\_\_\_\_\_  
Patient or authorized representative signature Date

South office: 664 Michigan Ave. Holland, MI 49423  
North office: 3290 N Wellness Dr Suite 120 Building D, Holland, MI 49424  
**P: (616) 392-5973 F: (616) 392-1646**