grand traverse children's clinic

3537 West Front Street, Suite G
Traverse City, MI 49684

ph: (231) 935-8822
fx: (231) 935-8837

Authorization for Release of Health Information

This form is to be used by patients, 18 years of age and older, who are giving us permission to speak with their parent(s) or other individual(s) regarding their medical history and or current records.

Patient's Name: _____ DOB: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

With whom may we speak regarding your medical history/records?	Relationship to Patient:
☐	
☐	
☐	

What information may we share with the listed individuals?

☐ **Entire medical record** *(this includes allowing them to schedule appointments for you, request refills on your medications, obtain test results, speak with the nurse/doctor regarding your entire medical record, etc.)*

☐ **Only Specific Dates:** _____ to _____

☐ Specific Information you **DO NOT** want released: _____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or Aids Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral &/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2). Any information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient and is therefore no longer protected by the federal privacy regulations. This authorization will expire upon written revocation.

I authorize and request any and all of my medical information, as indicated above, to be released according to the terms outlined in this agreement. Additionally, I certify that I am the patient and am over the age of 18 at the time of this authorization. My signature (below) confirms that the above statements are true and were made in good faith. I agree to defend, indemnify and hold Grand Traverse Children's Clinic, PC (as well as its employees) harmless from any claims and expenses, including attorney's fees, potentially arising from my actions related to same.

Authorized Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____