Grand Traverse Children's Clinic

3537 W. Front Street, Ste G
Traverse City, MI 49684
ph: (231) 935-8822
fx: (231) 935-8837

Robert Sprunk, MD
David Olson, MD
Andrew Tursman, MD
Lisa Chimner, MD
Jelanie Bush, MD
Katie Elms, MD

Consent to Release Medical Information

Patient's Name: ______________________________ DOB: ____________________
Address: ____
City, State ZIP: ____
Parent/Guardian Name & Contact Phone: ___________________________________

Physician releasing records:	Physician to receive records:
Name: ______________________	Name: ______________________
Address: ____________________	Address: ____________________
City: _______________________	City: _______________________
State & ZIP: _________________	State & ZIP: _________________
Phone: ( ) __________________	Phone: ( ) __________________
Fax: ( ) ____________________	Fax: ( ) ____________________

Reason for release of medical records: ________________________________

Medical Information to be sent:	
	Entire Medical Record -- ***INCLUDING*** information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, and testing or treatment of sexually transmitted disease and HIV/AIDS.
	Entire Medical Record -- ***EXCLUDING*** information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, and testing or treatment of sexually transmitted disease and HIV/AIDS.
	Record of care from ______ to ______ -- ***INCLUDING*** information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, and testing or treatment of sexually transmitted disease and HIV/AIDS.
	Record of care from ______ to ______ -- ***EXCLUDING*** information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, and testing or treatment of sexually transmitted disease and HIV/AIDS.

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, OR upon the 18th birthday IF release was signed by a legal guardian on behalf of the patient, and is inherently limited by the extent to which the release has already been executed.***

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, or legal guardian, 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: ____________________________________ RELATION TO PT: __________

WITNESS SIGNATURE: _________________________________ DATE: ________________

rev. 2/2016