grand traverse children's clinic

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

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

Consent to Release Medical Information

Patient's Name: _____ _____ _____ DOB: _____
Last *First* *MI*

Address: _____

City, State ZIP: _____

Parent/Guardian: _____ _____
Name *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 Information _____

	Medical information to be sent *(check one box below)*:
	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 diseases, 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 diseases, 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 and/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 I 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 attorneys fees, potentially arising from my actions related to same.*

Authorized Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

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