Harbour Towne Health PLLC

131 W. Seaway Drive, Suite 200
Muskegon, MI 49444
Phone: 231.375.8065
Fax: 231.375.8063

AUTHORIZATION FOR RELEASE
MEDICAL INFORMATION AND RECORDS

PATIENT NAME: _____ _____ _____
LAST FIRST MI

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

_____

DATE OF BIRTH _____ SSN# _____

I hereby authorize: _____ (provider/facility name)
_____ (address)
_____

Phone: _____ Fax: _____ **to release information from my medical records to HARBOUR TOWNE HEALTH PLLC for continuation of care.**

INFORMATION TO BE RELEASED: DATES:

□ History and physical exam _____
□ Progress notes _____
□ Lab reports _____
□ Imaging reports (X-rays,MRIs, CT) _____
□ Other: _____ _____
_____

I specifically authorize the release of medical information relating to:

□ **Substance abuse (including alcohol/drug abuse)**
□ **Medical health (including psychotherapy notes)**
□ **HIV related information (AIDS related information)**

X _____ _____
SIGNATURE OF PATIENT OF LEGAL GUARDIAN **DATE**

□ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

This information may be disclosed and used by the following individual or organization:
Release to: HARBOUR TOWNE HEALTH PLLC
Address: 131 W SEAWAY DRIVE, SUITE 200, MUSKEGON, MI 49444
Fax: (231)375-8063 □ **Please fax records**
Phone: (231) 375-8065 □ Please mail records

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information indicated on this form will be sent to the individual listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. The released information may not be copied, shared or re-released , except as consistent with the authorized purpose above. I understand that I am not required to sign this authorization, and that HARBOUR TOWNE HEALTH PLLC/ HARBOUR TOWNE HEALTH PROVIDER will not refuse me treatment if I refuse to sign. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

X _____ _____
Signature of Patient or Legal Representative **Date**

X_____ _____
Harbour Towne Health PLLC Office Staff Signature **Date**