Traverse Health Clinic
1719 S. Garfield Avenue
Traverse City, MI 49686

Fax: (231) 935-0962
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Traverse Health Clinic

Authorization to Release Health Information

Patient Name:		Birth Date:
Address:		
City:	State:	ZIP Code:

I hereby authorize: **Traverse Health Clinic**
and
(organization/provider/person)

Name: _____

Address:_____

Phone: _____Fax: _____

Relationship to Patient:_____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient records, including if any, alcohol and drug abuse records protected under the regulations of 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social service records; psychological services records, including communications made by me to a social worker or psychologist; and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex, (ARC), only under the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED:

___□ Admission/Discharge Letters & Summaries
___□ Communication Exchange
___□ History & Physical Examinations
___□ Lab & X-Ray Results
___□ Progress Reports
___□ Provider Assessments & Notes
___□ Psychiatric Evaluation
___□ Psychosocial Notes
___□ Reauthorization Forms
___□ Recovery/Aftercare Plan
___□ Treatment Plan(s)
___□ Other Information *(Specify)*
_____
_____

DATES OF SERVICE: □ _____/_____/_____ to _____/_____/_____

□ Duration of Clinical Services

Revised 8/2018

PURPOSE AND NEED FOR SUCH DISCLOSURE:		
___□ Continuation of Care	___□ Referral Follow-up	___□ Up Vocational Rehabilitation
___□ Disability Determination	___□ Return to Work	___□ Other:
___□ Insurance/Billing Verification	___□ School	_____
___□ Legal Follow-up	___□ Social Service Referral	_____

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the information and entries made in my medical record if I need help understanding them. This will prevent my misunderstanding of the information that has been written in the record. I will not hold Traverse Health Clinic liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.

I understand that it is my decision whether or not to sign this authorization, except in instances where my agreement is necessary for treatment, payment or health care operations. The organization/provider/person named in this authorization cannot refuse to treat me if I choose not to sign. I have the right to revoke this authorization at any time unless an organization/provider/person has already released information in reliance upon having it.

This authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given or a maximum period of one (1) year from date of signature.

Authorization Signature:	**Date:**
Witness:	**Date:**

Relationship to Patient:

□ If Patient is a minor or incapable of signing, a copy of the appropriate legal documentation is attached, if applicable.

□ Driver's License / Identification Verified, As Applicable

REVOCATION (optional) – If you want to revoke this authorization, send a written or electronic note to the privacy officer of the organization/provider/person that you authorized to release information, or sign below.

This authorization is revoked for the following specified dates, events, or conditions.

Date: _____Event: _____Condition:_____

Revocation Signature:	**Date:**
Witness:	**Date:**

This authorization is valid for one (1) year from date of signature.