PATIENT AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT NAME _____ **DOB** _____

Purpose of Request – I request and authorize the disclosure of release of my protected health information as identified below:

To / From:
(circle one)

Clearwater Family Medicine,
a division of Arcturus Healthcare
___ Leah Cecil, D.O.
___ Jill Schmitt, D.O.
64321 Van Dyke Rd
Washington Twp, MI 48095
Phone: 586-281-6000
Fax: 586-281-6001

To / From:
(circle one)

_____
Name of Provider / Physician

_____
Address

_____
City / State / Zip

_____
Phone Fax

Please check: ____ Colonoscopy ____ Pap ____ Mammogram ____ Immunizations
____ Labs ____ Diabetic Eye Exam ____ Other_____

Description of Information to be Disclosed – I authorize the disclosure of complete medical record, **including** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing of treatment of sexually transmitted diseases and HIV / AIDS.

Purpose of Disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

____ Change of Physician
____ Chart Update

Expirations or termination of authorization – This authorization is effective for one year from the date of execution, however, I may revoke it at any time by providing notice in writing to the above-named party. A photocopy may serve the same as an original.

_____ _____
Patient and/or legal guardian of patient **Date**

11-2005 **FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. Clearwater Family Medicine has contracted with DataFile to make copies. You may be required to pre-pay for copies; if not, then your copies will be mailed along with an invoice.**