Medical Information (HIPAA) Release Form

PATIENT NAME: **DATE OF BIRTH:**

By listing the persons below, I am authorizing any employee Brookside Family Medicine or Dr. Graetz MD, PLC to release information contained in my patient records, which may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any social services records, if any mental health records, including communications made by me to a social worker or mental health professional, if any and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

□ **Do not release any information to anyone.**

□ **I authorize information to be released to:**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

□ **Emergency Contact :** (this person will not be authorized access to any medical information unless indicated above.)

Name: _____ Relationship: _____ Phone: _____

Messages from doctor's office:

May include: Appointment confirmation and new prescriptions or refills that have been sent to your pharmacy.

I would like to receive appointment and prescription messages via: □ Text **or** □ Phone □ A.M. □ P.M.

Which number do you prefer for voice calls? □ home _____ □ cell _____

Do you prefer a detailed message or a brief message asking you to call back? □ **Leave full msg.** **or** □ **call back only**

The **Patient Portal** gives you online access to your information and allows you to communicate with your doctor.
You may ask any employee to activate your portal if you are not already activated.

*****An **email address** is needed:

_____

Patient Signature

Office Use: EMessenger_____ Contacts Entered_____ *2016* Post-It _____