Brookside Family Medicine PLC
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Authorization for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:
D.O.B.
Mailing Address:

Home Phone:

Requesting records from:
Previous Physician or Facility Name: _____

Phone: _____ Fax: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Purpose of Disclosure: Transfer of Care

Please fax records to 855-586-8399 or provide digital copy on USB drive, rather than sending a paper copy.
*****NO DISCS PLEASE*****

Information to be Released:

All office visit notes, lab tests, x-rays, consultation reports, problem lists - *unless specified dates follow.

*From ____/____/_____ to ____/____/_____

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released ***unless you restrict by initialing below:***

_____***Do not release Alcohol and/or Drug Abuse information.***
_____***Do not release Behavioral Health Information***

Acknowledgement of Understanding

- I understand the expiration date of this authorization is 180 days from the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, as already acted in reliance on it.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I understand that, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with Michigan law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that a photocopy or fax of this form is the same as the original.
- I understand, if applicable, that (1) my HIV test results may be released without my authorization to persons/organizations that have access under Michigan law, and that (2) a list of those persons/organizations is available upon request.

I authorize and request any and all of my medical information, as indicated above be released according to the terms outlined in this agreement.

Patient Signature: _____Date:_____

Signature of Authorized Person _____ Relationship to Patient _____

Witness Signature: _____Date:_____

This information may include any of the following, unless otherwise identified:

Alcohol or drug abuse, mental health treatment information protected under Title 42 of Code of Federal Regulations, Part II Serious communicable and infectious disease as defined by the Michigan Department of Community Health Code 1989, Act 174. Which includes Venereal Disease, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Comples (ARC) and Hepatitis. Revocation of this consent is available at any time, except to the extent that release of information has already occurred in reliance upon this consent. The duration of this consent without