NORTHERN PINES
HEALTH CENTER, PC

Authorization for Release of Health Information

Please complete all sections below.

SECTION 1: Patient Information (Please Print)

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH (MM/DD/YY)
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS	

SECTION 2: Specific Health information to be released or disclosed:

☐ **All Health Information**	☐ EKG/Cardiology Reports	☐ Diagnostic Test Reports	☐ Operation Reports
☐ Physician's Orders	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Consultation Reports	☐ Progress Notes	☐ Patient Allergies	☐ Billing Information
☐ Pathology Reports	☐ Discharge Summary	☐ Radiology Reports & Images	☐ Other _____

- **Limited Dates of Service: _____ If initialed here,** I authorize the Practice to disclose the above health information ONLY for the following dates of service: _____/_____/____ to _____/_____/_____.

SECTION 3: What Provider/Facility should the health information be requested FROM:

○ Northern Pines Health Center – 11293 N M-37 Suite A, Buckley, MI 49620 Phone:231-269-4185 Fax: 231-269-4461
○ Name, Address, Phone of Provider/Facility:_____
_____

SECTION 4: To whom is the requested Protected Health Information being released TO: (Select One)

○ Northern Pines Health Center – 11293 N M-37 Suite A, Buckley, MI 49620 Phone:231-269-4185 Fax: 231-269-4461

⬭ **Mitzie Hewitt, DO** ⬭ **Sydney Steger, PA-C** ⬭ **Christina Peltier, NP** ⬭ **Macie White, PA-C**

○ Myself – Paper copy via US Mail to address in Section 1
○ Other: I am the patient, or the legally authorized representative of the patient listed in Section 1 and request the protected Health Information as indicated on this form to be released to:

Individual/ Person Name		Company/Organization	
Street Address			
City	State	Zip	Phone Number

SECTION 5: Select Delivery Method for Protected Health Information

- ○ Paper Copy via US Mail to other Address: _____
- ○ Email (PDF)
- ○ Fax #: _____
- ○ Other Electronic Type (must be specific): _____

These records to include, if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; and psychological services records, including communications made by me to a social worker or psychologist and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174,1989) governing HIV, HIV Test, Acquired Immunodeficiency Syndrome (AIDS) and AIDS-related complex (ARC), as well as genetic and demographic information for the purposes and conditions designated within this document.

SECTION 6: Purpose of Request/Disclosure:

- Personal Use
- Other (Please Specify):_____

SECTION 7: Signature of Patient or Patient Representative

By signing this authorization, I consent to the disclosure of the information as stated within this document. I understand and agree to the following:

- I will not hold Northern Pines Health Center liable for any misrepresentation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.
- I understand that failure to provide all information requested may invalidate this authorization.
- I understand that I may refuse to sign this Authorization and that my health care cannot be conditioned upon signing this Authorization.
- I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

This Authorization will expire one year from date of signing or otherwise by my choice, in which case this consent will expire on the date of ____/____/____.

_____ _____ _____

Patient or Legal Representative Signature **Date** **Time**

_____

Legal Representative Relationship to Patient

- If patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable.

_____ _____ _____

Witness Signature **Date** **Time**

This Authorization is subject to a written revocation (cancelling) at any time except in those circumstances in which Northern Pines Health Center has taken certain actions in reliance on such Authorization. However, this Authorization shall be valid no longer than it is reasonably necessary to accomplish the purpose of the actions for which it was given.

REVOCATION (OPTIONAL) – This Authorization is revoked for the following specified dates, events, or conditions.

DATE: ___/____/____ EVENT: _____ CONDITION: _____

Authorization must be dated subsequent to the service that you are requesting except in cases of ongoing treatments.

IDENTITY VERIFIED BY:		
NAME:	**POSITION:**	**DATE:**
INFORMATION RELEASED BY:		
NAME:	**POSITION:**	**DATE:**