David Barney Family Medicine
6690 Crossings Dr. SE suite C, Grand Rapids, MI 49508
p: (616) 600-1885
f: (616) 600-2782

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please print all information. Form must be signed and dated.

Patient Name: ____

SSN (last four digits):______________________ Date of Birth: _____________________________

Purpose of request (who will be authorized to receive information) - I authorize David Barney Family Medicine to disclose or provide protected health information, about me, to the individual(s) listed below.

Who will be authorized to receive information (list the individual(s) who can receive your PHI):
Individual Name(s) and relationship to patient:

____

____

____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person or persons identified above:

- Entire patient record; or, check only those items of the record to be disclosed:
    - office notes
    - nursing home, home health, hospice, and other physician records
    - lab results, pathology reports
    - record of HIV and communicable disease testing
    - x-rays;
    - record of mental health or substance abuse treatment
    - financial history report (previous 3 years only).
    - Only send the following: ____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
- Patient Request • Other (please specify):_______________________________________

- I understand that this authorization is voluntary and I may revoke this authorization at any time. I understand my right not to sign this document preventing anyone from access to my medical record.

• You have the right to terminate this authorization at any time by submitting a written request to the practice manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

• The practice places no condition to sign this authorization on the delivery of healthcare or treatment. • We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

• You have the right to receive a copy of signed authorizations upon request.

_______________________________________ ____________________________ _______________

Signature of Patient (if minor, parent/guardian) Printed Name Date