Holland Hospital
PHYSICIAN OFFICES

# Authorization to Release/Obtain Medical Information

**Last Name:** _____ **First Name:** _____ **DOB:** _____
**Phone Number:** _____ **Email:** _____

I hereby authorize Lakeshore Health Partners and Holland Hospital Medical Groups to
□ disclose and/or □ obtain the following information contained in my medical record
from (Date) _____ to (Date) _____.

Name of person/organization to whom disclosure is to be released/obtained from:
Name: _____ City: _____ State: _____
Address: _____ Zip Code: _____

**Specific Information Authorized for Release**

□ Complete Medical Record
□ E. R. Reports
□ Discharge Summary
□ History and Physical
□ EKG(s)
□ XRay Reports/Films, Digital, CD
□ Operative Report
□ Rehab Services Report/ OT, PT, Cardiac
□ Pathology Report(s) / Lab
□ Progress Notes
□ Billing Records
□ Other: _____
□ Treatment Plan/Planning
□ Psychiatric History & Physical
□ Psychiatric Evaluation
□ Psychiatric Discharge Summary
□ Psychiatric Testing

**Purpose of Disclosure**

□ Attorney/Legal □ Insurance/Workers Comp □ Personal Reasons □ Treatment

I understand that this will include information relating to: acquired immunodeficiency syndrome (AIDS), infection with human immunodeficiency virus (HIV), AIDs related complex (ARC), sexually transmitted diseases, tuberculosis, hepatitis, communicable diseases, infectious diseases, treatment for alcohol and/or drug abuse, and/or behavioral health services.

**Release of Information**

1. I understand that this authorization extends to all medical records of other providers to the extent indicated above; this may include any information about substance abuse treatment, behavioral health services, communicable diseases and infectious diseases, including sexually transmitted diseases, HIV infection, acquired immunodeficiency related complex, venereal disease, hepatitis or tuberculosis.
2. I understand that I may inspect or copy the information to be disclosed and may, upon inspection, refuse to sign the authorization or may revoke this authorization at any time if already signed by sending a written revocation to Attn: Practice Manager at the office address below. I understand that the revocation will not apply to the information that already has been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, then this authorization will expire in six (6) months.
3. I understand that any disclosure of this information carries with it the potential for redisclosure and the information may not be protected by federal or state confidentiality rules or regulations
4. I understand that my continued or future treatment by or payment to Lakeshore Health Partners and Holland Hospital Medical Groups is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.
5. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive continued or future treatment.

□ I have been provided a copy of this authorization for my records.

Signature of Patient of Person Authorized to Consent: _____ Date: _____

Relationship, if not Patient, Legal Guardian – attach documentation: _____

Witness: _____ Witness: _____

If you have any questions, please contact the Practice Manager at your physician office.

Lakeshore Health Partners Zeeland Family Medicine
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