FAMILY DOCTORS OF VICKSBURG PC
13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____ **This authorization must be filled out completely.**

Patient Name: _____ Date of Birth: _____

I understand that _____ (please list the name of the facility releasing your records) is authorized by me to use or disclose protected health information. I understand that the information released may be re-disclosed by the recipient and may no longer be protected health information. I hereby authorize the above named facility, its physicians, agents and employees to release the following:

Please CHECK the appropriate lines:
*Please be as specific as possible. Most offices charge a fee for copying records.
Family Doctors of Vicksburg charges ¢.25 per page for medical records.

__ Diagnostic information
__ Hospital admission and discharge summaries
__ Immunization records
__ Mental health evaluations and records
__ HIV, AIDS, ARC, STD and hepatitis records
__ Specialty consult records
__ Office notes
__ Pathology and Operative reports
__ Specific Diagnosis _____
__ Alcohol and Drug Abuse
__ Previous Physician records _____
__ Specific Date(s) _____
__ Entire medical records (this includes all of the above listed items) Please include a brief description of why entire record is to be released.
_____

Release records to: Name: _____
Address: _____ Fax number: _____

The purpose of this release is: ___permanent transfer ___coordination of care (not transferring out of practice) or ___other reason: _____

This release will expire 1 year from the date of signature, but may be revoked at any time by giving written notice to Family Doctors of Vicksburg. This revocation will not cover actions already taken in accordance with this authorization. You are also advised that you have the right to inspect or copy the information to be released.

I UNDERSTAND AND AUTHORIZE THE MEDICAL INFORMATION TO BE RELEASED AS INDICATED ABOVE.

_____ _____
Signature of authorized person Relationship
(If signed by a representative, a copy of the POA must be attached or on file with our office)

Date: _____