



- 1900 Wealthy SE, Suite 150, Grand Rapids, MI 49506  
(616) 459-3158 (Phone) (616) 459-4714 (Fax)
- 2093 Health Drive SW., Suite 200, Wyoming, MI 49519  
(616) 977-9950 (Phone) (616) 977-9219 (Fax)

Dr. \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF MEDICAL OR FINANCIAL INFORMATION

**Please Print Information**

Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Former Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I hereby authorize: **Grand Valley Medical Specialists, PLC**

- |   |  |
|---|--|
| <input type="checkbox"/> 1900 Wealthy SE, Ste 150<br>Grand Rapids, MI 49506 | <input type="checkbox"/> 2093 Health Drive SW., Ste 200<br>Wyoming, MI 49519 |
|---|--|

to release ONLY MEDICAL **OR** MEDICAL & FINANCIAL (*please identify*) information and/or copies of my records to:

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. Information requested:

\_\_\_\_\_ Lab and/or x-ray reports, *Date* \_\_\_\_\_

\_\_\_\_\_ Operative reports, *Date* \_\_\_\_\_

\_\_\_\_\_ Records related to (*please specify*): \_\_\_\_\_, *Date* \_\_\_\_\_

\_\_\_\_\_ Financial records, *Date* \_\_\_\_\_

2. Purpose of disclosure: \_\_\_\_\_ Continued patient care \_\_\_\_\_ Personal use \_\_\_\_\_ Transferring to new physician

\_\_\_\_\_ Other, specify: \_\_\_\_\_

3. Medical information includes: information about communicable diseases, TB, STD, HIV, HIV testing, AIDS and ARC. It also includes information regarding alcohol, drug, and mental health related treatment.

4. I do not authorize release of (*please specify*): \_\_\_\_\_

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions and records from other health care providers will not be released with this consent. I also understand that this authorization may be revoked in writing by me (the patient or legal representative) at any time, except after the release described above has taken place.

This release will not expire unless date is written: \_\_\_\_\_

\_\_\_\_\_  
Patient's (or Legal Representative's) Signature Date

\_\_\_\_\_  
Witness' Signature Relation to Patient Date