



- 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
Grand Rapids, MI 49506 | <input type="checkbox"/> 2851 Michigan St., Ste 103
Grand Rapids, MI 49506 |
|---|---|

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 Date

Relation to Patient