AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Birthdate:_____

Medical Information From:	**Physician/person/company to receive records:**
Office: Jupiter Family Medicine PC	Name:_____
Address: 6290 Jupiter Avenue, Suite A	Address:_____
City, State, Zip: Belmont, MI 49306	City, State, Zip:_____
Phone: (616) 301-2500	Phone:_____

Medical Information to be sent:

____Entire Medical Record, INCLUDING information related to the treatment for substance abuse or dependency; Psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Entire Medical Records, EXCLUDING information related to the treatment for:
Substance abuse or dependency
Psychiatric or mental health treatment
Information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Record of care from _____ to _____ INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

____Record of care from _____ to _____ EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

I RECOGNIZE THAT UNDER the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I may limit the scope of the information that I authorize be disclosed. It is my expressed wish that all medical records of whatever kind as described above, be released, subject only to the limitations, if any, noted hereafter:_____
_____

____If deemed necessary by Doctor _____, I authorize this information to be sent via FAX transmission. HIV, AIDS, and Mental Health records may not be FAXED unless it is an emergency.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing written consent to the above named party.

I FURTHER UNDERSTAND that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and thereafter no longer subject to protection under HIPAA.

_____

Signature of Patient or Patient's Legal Guardian Date