Grand River Family Care
1881 W. Grand River, Okemos, MI 48864
517-339-2116/Fax: 517-999-2039

Authorization for Disclosure of Protected Health Information (Transfer Records to GRFC)

Please print all information, then sign and date at bottom.

Patient Name (please print)_____ Date of Birth:_____

I authorize the following office to disclose the protected health information for above patient:

PHYSICIAN/PRACTICE NAME:_____

Physician Address:_____
Complete Street Address City State Zip Code

PHYSICIAN/PRACTICE TELEPHONE NUMBER_____ FAX #_____

Information to be disclosed will include, as applicable, unless crossed out:

- **Alcohol, drug abuse & mental health treatment information protected under the regulations in Title 42 of the Code of Federal Regulations Part II.**
- **Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome – AIDS, and AIDS related complex-ARC, as defined by the Dept. of Community Health rules (1989 Public Act 174).**

Person or organization authorized to receive information: Grand River Family Care (address above)

Specific Type of information to be disclosed (mark below)

____Entire Record ____Immunization Records ____Records from date of service:_____

This information may be disclosed for the following purpose: (mark below)

____Continued Care ____Personal Use ____Attorney Use ____Insurance Use

Other_____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be redisclosed and no longer protected by those laws and regulations.

I understand that I may revoke this authorization at any time by notifying GRFC in writing by sending a letter to the attention of the Office Manager. However, the revocation will not be valid if GRFC has taken action in reliance on this authorization.

This authorization expires 90 days from date of the signature below unless otherwise requested.

_____ _____
Printed name of patient or patient's representative Relationship to minor

_____ _____
Signature of Patient (or Parent or Legal Guardian of Minor) Date

GRFC has verified the identification of patient's representative:

____Person known to staff ____Driver's License/State ID ____Other_____