Release of Medical Records

I, _____ authorize the release of my medical records
Name Birthdate

From:

_____ Address: _____

_____ Address: _____

To: Petoskey Family Medicine, P.C.
1890 U.S. 131 South
Petoskey, MI 49770
Fax: 231-487-6014

_____ Scott Hotchkiss, M.D.
_____ Samuel Minor, M.D.
_____ Susan Jones, C.F.N.P.
_____ Sarah Wadowski, PA-C

Specific type of information to be disclosed and dates of service:

_____ Any information related to my care for _____
_____ Progress Notes _____
_____ Discharge Summary _____
_____ History & Physical _____
_____ Operative Report/Pathology _____
_____ X-Ray/Lab _____
_____ Drug Testing _____
_____ Employment Physical _____
_____ Referral Physician/Hospital Records _____
_____ Other _____

Purpose and need for such disclosure:

_____ Continuation of treatment or health care follow up
_____ Billing Information
_____ Social Service Referral
_____ Disability Determination
_____ Workers Compensation
_____ Other

This authorization is subject to written revocation at any time to the extent that Petoskey Family Medicine has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of the signature. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPPA Privacy Standards. My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.

Signature of Patient _____ Date _____

Authorized Representative _____ Date _____

Witness (If required) _____ Date _____