GREAT LAKES ORTHOPAEDIC CENTER, P.C.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. Patient's Name SSN DOB

2. I authorize Great Lakes Orthopaedic Center, P.C. to release or disclose health information of the above named individual or organization (as disclosed below) to: _____ (the "Receiving Party"). Address:_____

3. This authorization is made in accordance with the federal and state law and is valid for a period of six months after being signed or until _____. Alternatively, this authorization shall expire if and when:_____

4. I understand that I may revoke this authorization at any time by sending a written revocation to Medical Records Department, Great Lakes Orthopaedic Center, 4045 West Royal Drive, Traverse City, Michigan, 49684, except to the extent that Great Lakes Orthopaedic Center has taken action in reliance on the authorization.

5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.

6. A description of the health information I authorize for use or disclosure is: ___my entire medical record. ___ **Workmans Compensation information only.** ___ **x-rays & x-ray reports from** _____(date). ___**visit notes from**_____(date). ___ **return to work form from** _____(date).____**billing records**_____(service dates). ___ other (please specify). _____

7. **RELEASE OF THE FOLLOWING INFORMATION REQUIRES SPECIAL CONSENT. PLEASE CHECK YES OR NO TO EACH ITEM.**

Yes____No____ Medical records or health information regarding drug & alcohol treatment care.
Yes____No____ Medical records or health information regarding HIV &/or AIDS.
Yes____No____ Medical records or health information regarding treatment for care of a mental health problem.
(note: psychiatric or mental health records received from a provider outside of Great Lakes Orthopaedic Center can not be released or inspected under this authorization.)

8. I understand that my continued or future treatment by or payment to Great Lakes Orthopaedic Center is not conditioned upon my providing or signing this authorization unless this authorization is provided for the purpose of providing data in connection with medical or clinical trial research.

9. I understand that if Great Lakes Orthopaedic Center has received Protected Health Information from another source, and plans to release it under this authorization, that I have the right to inspect or copy the health information Great Lakes Orthopaedic Center intends to use or disclose, pursuant to this authorization, and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

10. I understand & agree to pay copy & mailing costs for records & x-rays I am requesting. These fees have been explained to me. I have been provided with a copy of this authorization for my records. _____ (initials).

DATE:_____

WITNESS:_____ _____
Patient's or Legal Guardian Signature

WITNESS:_____

_____
Relationship to patient if other than patient or legal guardian. Attach documentation.

_____
Address and telephone # of Patient or Legal Guardian

IMPORTANT: This authorization must be filled out in its entirety in order to be valid.