



Authorization for Release of Medical Information

Please send requested information to the Family Practice checked below:

- _____ Beckwith Family Practice, 2680 Leonard NE, Grand Rapids, MI 49505 (616) 224-1515
- _____ Hudsonville Family Practice, 5445 32nd Ave., Hudsonville, MI 49426 (616) 457-3830
- _____ Rockford Family Practice, 590 Ten Mile Road, Rockford, MI 49341 (616) 866-9568
- _____ Walker Family Practice, 650 Three Mile Road NW, Walker, MI 49544 (616) 784-4717
- _____ Wyoming Family Practice, 5251 Clyde Park SW, Wyoming, MI 49509 (616) 532-1100

Please complete all areas marked with *. Failure to do so will delay release of your medical records.

Request for Records:

I hereby request _____

*(Name and Address of Physician/Organization)

to release the medical records of the person listed below:

*(Full Name of Patient)	*(Date of Birth)	*(Daytime Phone)
*(Street Address)	*(City/State)	*(Zip Code)

Release Records To:

*(Name of Physician/Organization)		
*(Street Address)	*(City/State)	*(Zip Code)

Reason for Release: (Optional)

***Information To Be Released:** (Dates and types of information; list all that apply)

I understand that there may be a reasonable fee to cover obtaining and/or copying of the medical record, or any part of the medical record and that the fee must be paid in full prior to my obtaining any such copies. I understand that this authorization may be revoked by me (the patient or representative) at any time, except to the extent that the information described above has already been released. This consent expires one year from the date on which it is signed. I understand that my health care provider may not condition treatment on my signing this Authorization. I understand that if the recipient is not a health care provider, the records will no longer be protected by federal privacy laws and may be re-disclosed to others.

I understand that unless I expressly direct otherwise, the custodian may release medical information about HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), STDs (sexually transmitted diseases), mental health and substance abuse screening and counseling. If you wish to restrict release of these records, please indicate the restrictions on the "Information To Be Released" line above.

*Patient's (or Legal Representative's) Signature/Relationship to patient

*Date

*Witness' Signature

*Date

The information contained in this document is confidential, proprietary or privileged and may be subject to protection under the Health Insurance Portability and Accountability Act of 1996 or other legal sanction. This document is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the message is strictly prohibited and may subject you to criminal or civil penalty.