Wattles Park Family Practice
1125 E. Michigan Avenue Ste. 5
Battle Creek, MI 49014
Phone:(269)969-6014 Fax : (269) 969-6085

Release of Health Care Information

Patient Name: _____ Minor Child Name: _____

Patient Address: _____ Date of Birth: _____

Phone Number: _____

Birth Date: _____

Social Security Number: _____

I am the patient, or the legally authorized representative of the patient listed above I request the following information to be released.

FROM:	**TO:**
PHONE: **FAX:**	**PHONE:** **FAX:**

Type of and amount of information to be disclosed is initialed as follows: (Please Initial)

____ Entire Medical Records

____ Operative Reports

____ Emergency Room Reports

____ Radiology Reports

____ Substance/Alcohol Abuse (if any)

____ Genetic Testing

____ Hospital Discharge Summary

____ Consultations

____ Laboratory Reports

____ History & Physical

____ AIDS/HIV (if any)

____ Psychological/Psychiatric Conditions (if any)

____ Other (Please Specify) _____

Purpose of the release/disclosure to other Physician/Company/Organization:

____ Continuance of Care

____ Transfer of Care

If transfer of care please give a reason: _____

____ Attorney/Legal

____ Insurance Company

____ Other (please specify below)

_____

I understand this authorization will expire, without my revocation, one year from the date of signing or if I am a minor, on the date I become an adult. I understand that I can revoke this authorization at any time except to the extent that action has been taken on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees.

Patient Name (Printed) _____ Date: _____

Patient/Parent/Legal Guardian Signature: _____ Relationship: _____