AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

DR KENNETH VOBACH, 110 EAST THIRD STREET, DAVISON MI 48423

PH: 810-412-5437 FX: 810-412-5448 EMAIL: [VOBACHOFFICE@GMAIL.COM](mailto:VOBACHOFFICE@GMAIL.COM)

(All blanks MUST be filled in)

Patient(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REALEASE FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific type of information to be disclosed:** \_\_\_ Any and ALL records\* \_\_\_ Diagnostic Records only

\_\_\_Laboratory Results only \_\_\_Immunization only \_\_\_Chart Notes only \_\_\_Consult Notes only

\*Communicable disease and infection information as defined by statue and Michigan Department of Public Health Rules (which include sexually transmitted infections STI, tuberculosis TB, hepatitis B, human immunodeficiency virus HPV, acquired immunodeficiency syndrome AIDS and AIDS related complex ARC.

\*Alcohol and or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

\*Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

**The purpose and need for disclosure: \_\_\_\_Transfer of Care \_\_\_\_Attorney Request \_\_\_\_Disability**

**\_\_\_\_Workers Comp \_\_\_\_Social Security \_\_\_\_Insurance \_\_\_\_Other**

I understand, as set forth in the practice’s Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under the federal and state laws and that this request may be processed via Healthcare Technologies of Mid-Michigan, Inc. (copy service).

I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the request use or disclosure. Further, if the Practice will receive payment for obtaining this information. I understand I will be notified of the same.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Without expressed written revocation, this consent expires after one year.

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Signature of Parent or Guardian Printed Name

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Relationship to Patient(s) Date