## Marquette Internal Medicine & Pediatric Associates, P.C.

**1414 W Fair Avenue, Suite 201**
**Marquette, MI 49855**
**(906) 225-4500**

# Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Patient Address: _____

| Release Records To: | Release Records From: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Reason for the request of medical records checked below:**

- ☐ Changing Physicians
- ☐ Other: Please Explain_____

**The specific information requested:**

If changing physicians, Marquette Internal Medicine & Pediatric Associates, P.C. releases two years of medical records at no cost. If you would like additional years sent or if you would like the records released to yourself, there will be a charge for the medical records.

- ☐ **2 years** of progress notes, labs, radiology, cardiology reports, operative reports, procedures, test results
  - o I would like the following additional years sent and agree to pay all costs incurred_____
- ☐ Pertinent records
- ☐ The following specific portions of my medical record:

  _____

**Sensitive Information:** Unless otherwise specified above, I understand that the information in my record may include information relating to communicable diseases, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug use.

**Re-disclosure:** I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

**Other Rights:**

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event or condition, this authorization will expire in six months.)

I further agree to pay the actual cost in preparing the copies of the requested medical records if a fee is required.

| Signature of Patient or Legal Representative | Date |
|---|---|
| If signed by a legal representative, relationship to patient: | |