4070 Lake Dr SE Ste 101
Grand Rapids, MI 49546
(P) 616-455-4114 (F) 616-455-4454

Authorization to Disclose Protected Health Information

I, (patient name) _____, authorize WMFH to disclose and/or release my protected health information to the individuals designated below:

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

Protected health information to be disclosed:

Check the applicable box

☐ My complete medical record including but not limited to: diagnoses, prognoses, office notes, reports, test results, diagnostic images, medications, treatments, mental health records, communicable diseases (including HIV and AIDS), alcohol and drug abuse treatment and financial/billing (3 years).

☐ My complete medical record as above **with the exception of**:

Check all that apply (records that you <u>do not</u> want disclosed)

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (describe)_____

This authorization will expire one year from the date of my signature below. I understand that I have the right to revoke this authorization by submitting a written request to the office Privacy Manager and will on will be effective upon written notice, except where a disclosure was made pursuant to a previous authorization.

_____ _____
Patient Name Date

_____
Patient Signature (if minor, Parent or Legal Guardian)