AUTHORIZATION FOR RELEASE OF INFORMATION

Cherry Bend Family Care, PLC

PATIENT / CLIENT NAME	DATE OF BIRTH

ADDRESS (street, city, state, zip)

Information to be released to / from (CIRCLE ONE)

CHERRY BEND FAMILY CARE, PLC
10223 East Cherry Bend Road
Traverse City, MI 49684

Phone: 231-929-7933
Fax: 231-929-7934

☐ **REBECCA ZIPSER HOFFMAN, D.O.** ☐ **JENNIFER CARRIER, FNP-C** ☐ **CARRIE MINTO, PA-C**

Information to be released to / from: _____
NAME PERSON(S) OR ORGANIZATION(S) FOR DISCLOSURE

_____
ADDRESS CITY STATE PHONE

FAX _____

Relationship of this person / organization to me: Primary Care Provider. Other _____

I hereby authorize the release of information contained in my patient records, **including alcohol and drug abuse records** protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, **social services records,** if any, and **psychological services records,** if any, **including communications made by me to a social work or psychologist,** if any, and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174, 1989) **governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS),** and **AIDS-related complex (ARC),** if any, to the individuals listed, only under the conditions listed:

SPECIFIC INFORMATION TO BE DISCLOSED

☐ HISTORY & PHYSICAL EXAMINATION ☐ PERTINENT INFORMATION (Specify) _____ ☐ OTHER (Specify information e.g., films, slides, etc.)
☐ TREATMENT PLAN
☐ PROGRESS REPORTS
☐ DISCHARGE SUMMARY
☐ ENTIRE CHART

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐ CONTINUATION OF CARE ☐ REFERRAL FOLLOW-UP ☐ OTHER: _____
☐ INSURANCE / BILLING VERIFICATION ☐ RETURN TO WORK
☐ SCHOOL

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret.

I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent may misunderstanding of the information that has been written in the record.

I will not hold Cherry Bend Family Care liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation.

This authorization is subject to a written revocation at any time except in those circumstances in which the Hospital has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire one year from the date of signing.

REVOCATION (optional) - This authorization is revoked for the following specified dates, events, or conditions.

Date:_____ Event:_____ Condition:_____

This authorization must be dated subsequent to the hospitalization that you are requesting except in cases of ongoing treatments.

SIGNATURE	DATE	WITNESS	DATE

RELATIONSHIP TO PATIENT	☐ IF PATIENT IS A MINOR OR INCAPABLE OF SIGNING, A COPY OF THE APPROPRIATE LEGAL DOCUMENTATION IS ATTACHED, IF APPLICABLE.