If you are 20yrs old or younger **DO NOT** send for previous medical records. The Physician will let you know at your appointment what records are needed.

Grand Traverse Internists, PC

Authorization for the Use and/or Disclosure of Protected Health Information

Please complete and send to your previous physician

Release Records *From*:

Former Doctor or Clinic Name:

Address: _____

I authorize the above person or entity to release **my medical records** or (*specify other*) _____

_____

For the purpose of:

____Continuation of Care _____Disability Determination

____Legal Reasons Other: (*specify other*) _____

Only the above referenced information may be used and/or disclosed pursuant to this authorization.

Send Records *To*:

I authorize the following person to **receive** my protected health information:

(Circle One): Dr. Oakley Dr. Klettner Dr. Bultemeier Dr. Yates

Dr. Wagner Dr. Hughes Mary Douglas, PA-C

At: **Grand Traverse Internal and Family Medicine, P.C.**
5015 N Royal Drive
Traverse City MI 49684
Phone: **231-935-0850**

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and submitted to the Privacy Officer at Grand Traverse Internists. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclosure my protected health information have acted in reliance upon this authorizations.

This authorization expires upon _____ (*insert date or event*.)

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protections regulations found under 45 C.F.R. 164.524).

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Grand Traverse Internists, PC, nor will it affect my eligibility for benefits.

_____ _____

Signature Date

_____ _____

Name (Print) Date of Birth

_____ _____

Name of Personal Representative Relationship to Patient