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 Internal & Family Medicine, 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 Internal & Family Medicine. 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 authorization.

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 42 C.F.R. part 2.

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 Internal & Family Medicine, PC, nor will it affect my eligibility for benefits.

_______________________	_______________________
Signature	Date
_______________________	_______________________
Name (Print)	Date of Birth
_______________________	_______________________
Name of Personal Representative	Relationship to Patient