ST JOHN CENTER FOR WELLNESS AND FAMILY MEDICINE
RECORDS *FROM* OUTSIDE PROVIDER

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I hereby authorize _____ to release protected health information about the above patient(s) as described below to: **St. John Center for Wellness and Family Medicine**, **Attn: Medical Records**

The specific information that should be disclosed is (note dates of service if restricted to specific dates):

_____Immunization records and test results Dates:_____
_____Office Visit notes Dates:_____
_____Consultation/hospital/ER records Dates:_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: **YES**, DISCLOSE THIS INFORMATION _____

NO, **DO NOT** DISCLOSE THIS INFORMATION _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies. Contact the facility you are transferring records from, for fee information.

I understand that the information released may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying _____ in writing, unless the information has already been released/disclosed. Authorization for release/disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

This authorization will expire automatically when the purpose for the release/disclosure has been achieved or upon 90 days after the signature date below, whichever is later.

Printed name of Requestor:

St. John Center for Wellness and Family Medicine
18303 Ten Mile Rd. Suite 500
Roseville, MI 48066
Phone Number: 586.498.5160
Fax Number: 586.498.5199

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____
Signature of patient or parent/guardian Date of Signature

_____
Relationship if other than patient signature