Family Medicine Specialists, PC
721 3 Mile Rd N.W. Suite 200
Grand Rapids, Michigan 49544
Phone: (616) 647-3770
Fax: (616) 647-3788

I understand there may be a fee associated with copying of Medical Records. CIOX (1-800-367-1500) has been contracted to process medical requests and will charge based on the State of Michigan fee schedules

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient's Full Name ______________________________ **Birth date** ______________

Address: ____

City:____________________ **State**:____________ **Zip Code**:__________ **Phone:** __________________

Information to be released from:	**Information to be release to:**
REQUEST MUST HAVE COMPLETE ADDRESS & FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS & FAX NUMBER**
Name/Facility______________________________	Name/Facility______________________________
Address: _________________________________	Address: _________________________________
City:_______________ State:_____ Zip Code:______	City:_______________ State:_____ Zip Code:______
Phone: ______________ Fax: ________________	Phone: ______________ Fax: ________________

Information to be Released (check all that apply)

- o Office visits @ FMS
- o Complete Chart
- o Specialists Consults
- o Imaging Reports
- o Laboratory Reports
- o Other_____________
- o Behavioral/Mental Health
- o Radiology Reports

If you DO NOT WANT any of the specific information below released, Check the box(es) below:

- **AIDS OR HIV testing information or test results**
- **Substances abuse/alcohol treatment**
- **Mental Health and Behavioral records**
- **Other: ____________________**

Purpose for Disclosure: Patient request ______ Attorney/legal ______ Insurance______ Transferring PCP______ Other______

(Purpose for disclosure must be completed prior to processing. e.g., continuing care, personal use, legal)
Dates of service to release (FROM): __________ **(TO):__________**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the privacy contact at Family Medicine Specialists. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed.**

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X______________________________________ ________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date:

____

Printed name of Authorized Representative Relationship / Capacity to patient