UNIVERSITY EYE CENTER
FERRIS STATE UNIVERSITY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Telephone: H_____ W_____

The following individual/organization is authorized to make the disclosure:	**The purpose of the disclosure is:**
Physician/Medical Office: _____	☐ Change of Insurance
Street/Suite: _____	☐ Continuation of Care
City/State/Zip: _____	☐ Referral
Phone: _____ Fax: _____	☐ Other:_____

The type and amount of information to be used or disclosed is as follows:

☐ 2 years back with most recent records
☐ 5 years back with most recent records
☐ Specific information _____

RESTRICTIONS: Only medical records that have originated through this health care facility will be photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:	
Release to: _____	☐ Please mail copies to the address indicated in previous box.
Street/Suite: _____	☐ I am planning to pick-up the copies. Please call me when they have been copied.
City/State/Zip: _____	
Phone: _____ Fax: _____	

I understand that I have a right to 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 health information management department. 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. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

_____ _____ _____
(Witness) Printed name of authorized representative Relationship/Capacity to Patient

_____
Address and telephone number of authorized representative

1124 S. State Street, MCO 101D
Big Rapids, MI 49307-2256

Phone: (231) 591-2020
Fax: (231) 591-3991
Web: www.ferris.edu/mco

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