

## UNIVERSITY EYE CENTER FERRIS STATE UNIVERSITY

## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Physician/Medical Office:   Change of Insurance   Change of Insurance   Continuation of Care   City/State/Zip:   Continuation of Care   Referral   Other:		Date of Birth:		
The following individual/organization is authorized to make the disclosure:    The purpose of the disclosed Physician/Medical Office:   Change of Insurance   Change of Insurance   Continuation of Care   Referral   Change of Insurance   Continuation of Care   Referral   Cother:   Continuation of Care   Referral   Cother:   Change of Insurance   Continuation of Care   Referral   Cother:   Change of Insurance   Continuation of Care   Referral   Cother:	Address:	City/St	ate/Zip:	
Physician/Medical Office:   Change of Insurance   Change of Insurance   Continuation of Care   City/State/Zip:   Change of Insurance   Continuation of Care   Referral   Phone:   Fax:   Other:   Other:   Other:   Phone:   Fax:   Other:   Other:   Other:   Phone:   Fax:   Other:   Ot	Telephone: H	W		
City/State/Zip:	Physician/Medical Office:			
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 reque authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authoriza understand the information in my health record may include information relating to sexually transmitted disease, acquired immunoc syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health ser treatment for alcohol and drug abuse.  This information may be disclosed and used by the following individual or organization:  Release to:  Street/Suite:  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 and present my written revocation to the health information management department. I understand that the revocation will not apply information that has already been released in response to this authorization. I understand that the revocation will not apply to my instruction the following date, event, or condition:  If I fail to specify an expiration date, event or condition:  If I fail to specify an expiration date, event or condition:  I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign my 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 famillar with and fully understand the terms and conditions of this authorization.	City/State/Zip:			☐ Referral
2 years back with most recent records 5 years back with most recent records 6 years back with back back or patients years and including the date the patient signed the authorization relating to a sexually transmitted disease, acquired immunor syndrome (HIV). It may also include information about behavioral or mental health ser treatment for alcohol and drug abuse.  This information may be disclosed and used by the following individual or organization:  Belease to:    Please mail copies to the address indica previous box.  Street/Suite:    Please mail copies to the address indica previous box.  Street/Suite:    I am planning to pick-up the copies. Please most when they have been copies.    I am planning to pick-up the copies. Please me when they have been copied.    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 and present my written revocation will not apply to my instructions of 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 authorizat	Phone:	Fax:		U Other:
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