

Michigan Hand Center, PLC
1111 Leffingwell NE
Suite 200
Grand Rapids, MI 49525

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ DOB _____

Phone(____) _____ Address _____

City _____ State _____ Zip _____

Records From:

Name _____

Address _____

City _____

Phone (____) _____

Fax (____) _____

Records to be sent To:

Name _____

Address _____

Address _____

City _____

Phone(____) _____

Medical Information to be sent:

Fax #(____) _____

____ Initial Evaluation Report ____ Progress Notes ____ Outside Test Results

____ Therapy Notes

____ Other (please specify) _____

I understand that I have the right to revoke this authorization in writing and acknowledge that Michigan Hand Center, PLC will use or disclose my protected health information in reliance upon this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use or disclosure of my protected health information in accordance with the terms of this authorization.

Patient or Patients Legal Guardian

Date

Authorization Expiration Date

Our practice may condition the provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.