Authorization for disclosure of Health Care Information Released
FROM
Mercy Family Care

☐ Mercy Family Care – Grayling
1250 E. Michigan Avenue
Grayling, MI 49738
989-348-0550
Fax 989-348-0473

☐ Mercy Family Care – Roscommon
234 Lake Street
Roscommon, MI 48653
989-275-1200
Fax 989-275-1210

☐ Mercy Family Care – Prudenville
2585 W. Houghton Lake Dr
Prudenville, MI 48651
989-366-2900
Fax 989-366-1166

Please send a copy of my health information to:

Name of Provider _____

Address _____

City _____

State _____

Phone Number _____

Fax Number _____

Reason for Information Request

☐ Continuation of Care
☐ Transferring Care
☐ Personal Use
☐ Insurance Billing
☐ Other

*** Specific information to be disclosed:

☐ Any and all Medical Records (excluding records from other health care facilities);
☐ Workman's compensation notes only
☐ Test Results
☐ Discharge Summary
☐ History & Physical
☐ Operative Reports
☐ Progress Notes
☐ Pathology Reports
☐ Laboratory Reports
☐ X-ray Reports
☐ EKG Report
☐ Other Reports
_____
_____

Date(s) of Treatment _____

This statement must be signed and dated, and is subject to written revocation at any time except in those circumstances in which the office has taken certain actions prior to revocation. This authorization will **expire one (1) year from the date of signing or otherwise by my choice**, in which case this consent will expire on _____.
(Date or Event)

I hereby state that I have read and fully understand the above statements. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above. I understand that I may refuse to sign this authorization and that my health care cannot be conditioned upon signing this authorization. I may inspect or request a copy of information and disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or a health plan that is covered by federal privacy regulations (HIPAA), the information described above may be re-disclosed and no longer protected by these regulations.

Print Name | Signature of Responsible Party | Date

Patient Date of Birth | Patient Social Security Number

Signature of Witness | Date

**********Office Use Only**********

Name of person sending records _____
Date records were sent _____
Records were sent via _____ Mail _____ Fax _____ Other

SENDING RECORDS (Blue Paper)