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

Please send a copy of my health information to:

- ☐ 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 complete this section about the provider we are requesting records from:

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 Reports
- ☐ Other
  _____
  _____

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 Clerk Sending Release _____

Date Release was sent _____ Release was sent via _____ Mail _____ Fax _____ Other