Cassopolis
Family Clinic Network
Our Family. Caring For Yours.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please Print

Patient Name: _____ Maiden Name: _____ (For a child): _____

DOB: _____ Last 4 digits of SS#: _____

Authorize:

☐ **Cassopolis Family Clinic**
261 M-62 North, Cassopolis, MI 49031
Phone: (269) 445-3874 Fax: (269) 445-2076

☐ **Cassopolis Family Clinic Dental**
261 M-62 North, Cassopolis, MI 49031
Phone: (269) 228-8500 Fax: (269) 445-1928

☐ **Niles Community Health Center**
1951 Oak Street, Niles, MI 49120
Phone: (269) 262-4749 Fax: (269) 262-4739
East Wing Fax: (269) 240-9020

☐ **Niles Community Health Center Dental**
122 Grant Street, Niles, MI 49120
Phone: (269) 262-4364 Fax: (269) 340-5981

☐ **Niles Community Health Center OB/GYN**
1951 Oak Street, Niles, MI 49120
Phone: (269) 683-0300 Fax: (269) 683-0398

To disclose the following information:

☐ All health records **OR** ☐ Medication lists ☐ Office notes ☐ Lab/Pathology ☐ Operative report ☐ Dental records
☐ OB records ☐ Consultation ☐ ER visit ☐ EKG/EEG/Results ☐ X-ray/Ultrasound ☐ Sexually transmitted disease
☐ HIV/AIDS ☐ Other _____

Time period from: _____ to _____
Month/Year Month/Year

☐ Request my records from location below ☐ Send my records to location below

PHYSICIAN / HOSPITAL / AGENCY: _____

Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ Fax: _____

This authorization shall be in force and effective for one (1) year.

I understand that, as set forth in the Health Center's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: **Cassopolis Family Clinic Network, Attn: Privacy Officer, 261 M-62 North, Cassopolis, MI 49031**

If I choose to do so, I understand that my revocation will not effect any actions taken by Cassopolis Family Clinic Network before receiving my revocation.

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by the federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to receive a copy of the Notice of Privacy Practices and that I have the right to read it before signing this consent.

The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal law. State & federal law specifically requires that any patient medical record and/or personal healthcare information containing drug & alcohol diagnosis & treatment, mental health & sexually transmitted diseases, including HIV/AIDS are privileged & confidential & may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ _____ _____
Signature of Patient or Personal Representative Printed Name Date

For Office Use: Copies:_____ Faxed: _____ Mailed:_____ Picked Up:_____

Appointment with Provider: _____ Appointment date: _____