*Day*One

Family Healthcare P.C.

*Start with us...stay with us, from Day*One

363 Fremont Street, Suite 203 • Battle Creek, MI 49017-3336

269 969 6123

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: ____________________

Date of Birth: ____________________

Patient Address: ____________________

____

____

I Understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of supplies, and labor, and postage related to the production of my information. I understand that the charge for this service is $10.00 initial fee per request, plus $1.00 per page for the first 20 pages, $.50 cents per page for pages 21-50, $.20 cents per page for pages 51 and beyond. The charge for families (3 or more) is $25.00 initial fee per request, plus $1.00 per page for the first 20 pages, $.50 cents per page for pages 21-50, $.20 cents per page for pages 51 and beyond.

____________________ ____________

Signature of Patient or Legal Guardian Date

____

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSE ONLY:

Date notified/ Total Charges

DayOne Family Healthcare, P.C.
363 Fremont Street, Suite 203
Battle Creek, MI 49017
PH: (269)969-6123 FAX: (269)969-6122

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT FULL NAME____

DATE OF BIRTH________________________SS#________________________

I HEREBY AUTHORIZE:

____
(Practice Name and Address)

TO RELEASE MEDICAL INFORMATION TO:

____
(Practice Name and Address)

INFORMATION TO BE RELEASED (PLEASE INITIAL APPROPRIATE LINE):

________ENTIRE MEDICAL RECORD EXCLUDING INFORMATION RELATED TO HIV OR AIDS INFECTION, OR THE FOLLOWING (IF APPLICABLE):
________LAST TWO YEARS OF ALL TESTING, THREE YEARS CORRESPONDENCE FROM SPECIALISTS, IMMUNIZATION RECORDS, GROWTH CHARTS (FOR CHILDREN UNDER 5)
________MEDICAL INFORMATION RELATED TO HIV/AIDS INFECTION
________ANY RECORD OF TREATMENT FOR DRUG AND/OR ALCOHOL DEPENDENCY OR ABUSE
________ANY RECORD OF MENTAL HEALTH TREATMENT
________SPECIFICALLY ONLY THE FOLLOWING:________________________

PURPOSE OF RELEASE: ___TRANSFER CARE REASON FOR TRANSFER______________
____

___COORDINATION OF CARE ___ SHARED INFORMATION
___REFERRAL ___ NO REASON GIVEN

The practice will______, or will not______ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in relation to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except when the practice has already taken action upon this authorization. I acknowledge that I may receive a copy of this authorization. This release is effective for six (6) months from the date of signing.

____ ________________________
Patient Signature or Parent/Legal Guardian Dated

____ ________________________
Witness Relationship to Patient