DayOne
FAMILY HEALTHCARE

363 Fremont St., Suite 203
Battle Creek MI 49017
P: (269) 969-6123 F: (269) 969-6122
www.dayonehealthcare.com

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): If transferring out of practice, there is a fee after the first 5 pages of records. See cost of records release.

_____LAST YEAR OF ALL TESTING, THREE YEARS CORRESPONDENCE FROM SPECIALISTS, IMMUNIZATION RECORDS, GROWTH CHARS (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
_____ELECTRONIC COPY OF RECORDS
_____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 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 HIPPA Privacy Rule. I have the right to revoke this authorization in writing expect 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

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363 Fremont St., Suite 203 | Battle Creek MI 49017 | P: (269) 969-6123 | F: (269) 788-3411 Ext. 390
www.dayonehealthcare.com

Date: _____

Dear: _____

We have received our request for medical record information on your patient:

_____ DOB _____

There is a fee of $_____for the completion of this type of information. We will be glad to remit the information requested upon the receipt of your advance payment.

For your information the fee schedule is as follows: Copying charges, including the cost of supplies and labor, and postage related to the production of my information. The charge associated with records will be the following: Per page for the first 20 pages will be $1.25, per page for pages 21-50 will be $0.63 and anything beyond 50 pages will be $0.25 per page.

Thank you for your cooperation.

Sincerely,

Medical Records