Hastings Internal and Family Medicine
225 S M-37, Suite 1
Hastings, MI 49058

Telephone 269-948-0078
Fax 269-948-0099

Authorization for Release of Medical Information to Hastings Internal and Family Medicine

_____

Patient Name | Date of Birth | Today's Date

I authorize _____
Name of Practice or Individual

_____
Address

_____
Telephone Number | Fax Number

to disclose or provide the following protected health information about me to:

Hastings Internal and Family Medicine
225 S M-37, Suite 1
Hastings, MI 49058
Fax 269-948-0099

☐ Entire patient record; (or, check only those items of the record to be disclosed below)

- ☐ Office/Consult notes
- ☐ Lab/X-ray results, pathology reports,
- ☐ Financial History
- ☐ Immunization record
- ☐ Immunization record
- ☐ Medical Summary
- ☐ Confidential record of HIV and communicable disease testing
- ☐ Confidential records of mental health or substance abuse treatment
- ☐ Only the following:_____
- ☐ Dates: _____

Purpose for release:
- ☐ Transfer of care
- ☐ Continuing care or consultation
- ☐ Request of patient or legal representative

- This release is effective for one year from the date of signature. It may be revoked at any time by providing written notice to the practice or individual listed above.
- A facsimile or photocopy of this document may be accepted in lieu of the original.
- Medical records released to Hastings Internal and Family Medicine are subject to privacy protections under the Health Insurance Accountability and Portability act, and may not be further released without specific written authorization.

_____

Signature of Patient or Legal Representative | Relationship to patient if applicable | Date

_____

Signature of Witness | Date