NEW PATIENT AUTHORIZATION
TO RELEASE HEALTHCARE INFORMATION

The HIPAA Privacy Rule allows Cadillac Family Physicians PC, a HIPAA covered entity, to request Private Health Information (PHI) maintained by a medical institution be released records per the patient's instructions. This includes the right to obtain a copy as well as direct transmission of a copy of the individual patient, designated person, or entity. Please complete the information below to provide clear printed instructions for the Medical Records team to follow to collect information for your initial appointment.

Patient Information:

Name: _____ Date of Birth: _____

Street Address: _____

City, State & Zip Code: _____

Phone Numbers (Home/Cell): _____

I hereby authorize (records from):

Name of facility: _____

Street Address: _____

City, State & Zip Code: _____

Phone Number: _____ Fax Number: _____

RELEASE RECORDS TO (going to):

Mailing Address: Cadillac Family Physicians PC, 8950 Professional Drive, Cadillac, MI 49601

Preferred Method of delivery is: Electronic FAX (231) 779-7701

Specific types of information and date(s) of treatment to be disclosed:

The *MOST RECENT/LATEST Patient summary* of Physical/Annual Exam, 2 Office Visits, Current Consult Reports, Colonoscopy, Chest X-Ray, EKG, Echocardiogram, Mammogram, Ultrasound and 1 year of Lab Results. Please return a copy of this Release form and documents within 15 days or ASAP.

Purpose of release: ◯ Transfer of Care to Cadillac Family Physicians PC

This authorization gives (Primary Care Provider) _____ *permission to release protected health information, which may include treatment of drug or alcohol abuse, drug related conditions, psychiatric/psychological conditions, or infectious disease (including HIV/AIDS or other communicable diseases.)*

A photocopy/fax of this authorization will be treated in the same way as an original. Information provided may include records that are received from other organizations. By signing this authorization, you release the medical provider from any and all liability resulting from the disclosure.

Signature: _____ Date: _____

Relationship to patient (if appropriate): _____