# Release of Medical Records

I, _____authorize the release of my medical records
Name Birthdate

From: _____

Address: _____

Phone: _____ Fax: _____

To: Petoskey Family Medicine, P.C.
1890 U.S. 131 South
Petoskey, MI 49770
Fax: 231-487-6014

_____Scott Hotchkiss, M.D.
_____Samuel Minor, M.D.
_____Carolyn Wiese, PA-C
_____Nicole Wolf, PA-C

Specific type of information to be disclosed and dates of service:
_____Any information related to my care for _____
_____Progress Notes_____
_____Discharge Summary_____
_____History & Physical_____
_____Operative Report/Pathology_____
_____X-Ray/Lab_____
_____Drug Testing_____
_____Employment Physical_____
_____Referral Physician/Hospital Records_____
_____Other_____

Purpose and need for such disclosure:
_____Continuation of treatment or health care follow up
_____Billing Information
_____Social Service Referral
_____Disability Determination
_____Workers Compensation
_____Other

This authorization is subject to written revocation at any time to the extent that Petoskey Family Medicine has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of the signature. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPPA Privacy Standards. My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.

Signature of Patient_____Date_____

Authorized Representative_____Date_____

Witness (if required) _____Date_____