

DayOne

Family Healthcare P.C.

Start with us...stay with us, from DayOne
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