Little Traverse Bay Bands Health Center
1260 Crane Ave
Petoskey, MI 49770
Phone: (231) 242-1700 Fax: (231) 242-1717

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City:_____ State:_____ Zip:_____

**I authorize LTBB to**: □ Disclose to □ Receive from □ Both Disclose to and receive from

Name: _____ Phone #:_____

Address: _____

the following information relative to treatment received from _____ to_____
start date of services requested End date of Services requested

**PLEASE CHECK REQUESTED ITEM(S):**

□ Laboratory Reports □ Dental Records □ Immunization Record □ Complete Medical Record (designated record set)
□ Behavioral Health □ Alcohol and Substance Abuse Records □ Dental Images □ Diabetes Management
□ Face Sheet □ Medication Records □ Other: _____
□ Test Result(s) of: _____

**The purpose for this request:** □ Legal □ Insurance □ Personal □ Continuation of Care

□ Other_____

**By signing this authorization form, I understand that:**

- My health information may be shared electronically.
- I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures.
- The sharing of my health information will follow state and federal laws and regulations.
- I understand that the information in my health record may include information related to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.
- I can withdraw my consent at any time; however, the revocation will not apply to information that has already been released in response to this authorization.
- This authorization of release of information will expire on _____ or one year after the date signed if not specified.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date of Signature

| FOR OFFICE USE ONLY | |
|---|---|
| Staff Person Releasing Information: | |
| Date Information Released: | Record #: |