Northview Medical House Calls
1184 Cleaver Rd Suite 300
Caro, MI 48723
Phone: 888-758-5709 Fax: 888-491-7220

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, upon appropriate completion of this authorization.

Patient Last Name _____ First Name _____ MI ___ Maiden/Other Name _____ ____/____/____ Date of Birth

Phone Number _____ Street Address _____ City and State _____ Zip Code _____

You are affiliated with Northview Medical House Calls and its member organizations and so authorized to request medical information on behalf of the patient for further treatment. NOTE: Healthcare providers may request medical information from another provider for further treatment as codified at *45 CFR 164.506(b)2 and (c)2* of the HIPAA Privacy Rule.

Date(s) of service requested: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Purpose of release: ☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Legal
(REQUIRED) ☐ Other (fill-in):

Release the information from (***LEAVE BLANK)*** _____

Disclose the information to:

Name:
Address: _____

Name: **Northview Medical House Calls**
Address: **1184 Cleaver Rd Suite 300**
Caro, MI 48723
FAX: 888-491-7220

Requested medical information (Check those that apply):

☐ Emergency Record ☐ Pathology Report ☐ Psychological Testing ☐ Physician Office Medical Record
☐ Discharge Summary ☐ Lab Reports ☐ Psychosocial History
☐ History and Physical ☐ Physical Therapy, Occupational Therapy or Speech Therapy ☐ Cardiac Catheterization Report ☐ Other: _____
☐ Consultations ☐ Cardiac Diagnostic Testing
☐ Progress Notes ☐ Psychiatric Assessments ☐ EKG/EEG Reports
☐ Report of Operation ☐ Psychiatric Evaluation ☐ Radiology Reports

NOTE: While Northview Medical House Calls and its member organizations makes every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of redisclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. This authorization has no expiration date.

X _____ Signature of Requestor _____ Relationship to Patient (or self) ____/____/____ Date

_____ ____/____/____
Signature of Parent/Guardian (minors age 0-17) **Date**

(THE AREA BELOW IS FOR NORTHVIEW MEDICAL HOUSE CALLS AND ITS MEMBER ORGANIZATIONS' USE ONLY.)

Printed name of employee processing this request: Date received: ____/____/____

Date Processed: ____/____/____ Medical Record Number/Account Number(s):

------Leave this area blank ------