Orthopaedic Associates of MICHIGAN

Return Completed Form To: Attn Medical Records
(by mail, fax or unsecure email) -1111 Leffingwell NE, Grand Rapids, MI 49525
- Fax: 616.336.5042
-Unsecure Email: forms@oamichigan.com

Medical Record Release Authorization

Patient Full Name _____ Date of Birth _____

Address _____

I hereby authorize release of records FROM:

Orthopaedic Associates of Michigan
Fax# 616.336.5042
Ph# 616.459.7101

Records to be Released TO:

Name _____

Address _____

City/State/Zip _____

Ph# _____ Fax# _____

OR ☐ pick up at 1111 Leffingwell NE, Grand Rapids, MI 49525

Purpose of disclosure

☐Patient Request ☐Other (please specify) _____

Records from Date Range _____ to _____

☐ Office Notes
☐ Operative Reports
☐ Lab Path Reports
☐ Cardiology/EKG Reports
☐ Radiology/X-ray/MRI *REPORTS*
☐ Radiology/X-ray/MRI *IMAGES* (**select one** for copy of images)*
☐ Independent Medical Exam (IME)

O *Secure Email (24 - 48 hrs)* O *Placed on Disk (7-10 business days)*

Other (specify) _____ Patient email_____(images only)

*Radiology IMAGES can be emailed through our secure imaging portal, all other records will be sent as directed above

This authorization will expire 12 months from your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if sooner than 12 months_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Form must be signed and dated each year.

_____ _____
Patient or Legal Representative Signature Date Signed

_____ _____
Printed Name Relationship

You have the right to receive a copy of this signed authorizations upon request.

Revised Sept 2022