OAM Orthopaedic Associates of Muskegon
West Michigan Spine Center
Grand Haven Bone & Joint

www.oamkg.com
www.wmspinecenter.com
www.ghboneandjoint.com

☐ 1400 Mercy Dr., Suite 100, Muskegon MI 49444 **231-733-1326**
☐ 1445 Sheldon Rd., Suite G1, Grand Haven MI 49417 **616-296-9100**

Authorization for Release of Medical Information (ONE PER REQUEST)

Patient Name: ______________________________ DOB: ______________

Maiden name or other name patient may have been know by: ______________________________

The above named is requesting that Orthopaedic Associates of Muskegon (OAM): (check one)

☐ Release health information to the person/company/agency/facility/listed below.

☐ Obtain from the person/company/agency/facility/listed below.

Name, Position, or Department: ______________________________

Name of Organization: ______________________________

Address of Organization: ______________________________

The information to be disclosed relates to the service dates beginning: ____________ and ending: ____________

☐ Entire Medical Record ☐ Physician Office Notes Other: ______________

☐ History & Physicial ☐ Test Results (labs, x-rays, etc) Other: ______________

☐ Medical/Surgical History ☐ Other Assessments Other: ______________

Conditions and Notifications: This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by providing OAM request in writing. It will be effective on the date received except to the extent that action has already taken place prior to the receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law.

Signatures: I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by the federal privacy regulations and, therefore may be subject to re-disclosure.

Signature of Patient/Personal Representative: ______________________________ Date: ______________

Print Name of Patient/Personal Representative: ______________________________

Relationship to Patient: ______________________________

*** I understand that in compliance with Michigan statute, I will pay a fee of $20 (and $10 for each additional request).**
There is no charge for medical records if the copies are being sent to facilities for ongoing care or follow up treatment.

Date Request Filled: ________ Released By: ________ Fee Collected: ________ User: ________

WHEN COMPLETE, PLEASE FAX BACK TO 231-733-5212