GHP
Grand Health
PARTNERS

SPECIALIZING IN SURGICAL AND MEDICAL WEIGHT LOSS

Consent to Release Medical Information

Patient: _____ Date of Birth: _____

Records From: _____Phone: _____
(Primary Care Physician/Specialist/Hospital)

Address: _____ Fax: _____

_____

Release Information to (Physician Name): _____

Grand Health Partners
2060 East Paris Ave SE
Suite 100
Grand Rapids, MI 49546
Phone: (616) 956-6100
Fax: (616) 956-6637

Authorization for:

_____Entire medical record, *including* information related to the treatment or substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV / AIDS or AIDS-Related Complex (ARC)

_____Limit this authorization to the following medical records: _____

I authorize medical information to be released as indicated above. I understand this release is effective for six months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party. If deemed necessary, I authorize this information to be sent via fax transmission.

Patient or Patient's Guardian Date

Witness Date

RANDAL BAKER, M.D., F.A.C.S. | JAMES FOOTE, M.D., F.A.C.S. | PAUL KEMMETER, M.D., F.A.C.S. | DEREK NAGLE, M.D., F.A.C.S. | JEREMY BUSHMAN, M.D. | ERIC KREBILL, M.D. | DAWN WHITE, M.D.| JENNIFER SANDY, D.O.

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