GRAND HEALTH PARTNERS
TRANSFORMATIONS HAPPEN DAILY

Consent to Release Medical Information

Patient: _____ Date of Birth: _____

Records From: _____ Phone: _____

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. | 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.
Katherine Stam, D.O.

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