Thirlby Clinic

Medical Information (HIPAA) Release

Primary Care Provider: _____
*** Please return prior to appt ***

Patient Name: _____ DOB: _____/_____/_____

By listing the persons below, I am authorizing any employee of Thirlby Clinic, PC, to release information contained in my patient records, which may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any social services records, if any mental health records, including communications made by me to a social worker or mental health professional, if any and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to:

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

☐ Emergency Contact: (this person will not be authorized access to any medical information unless indicated above)

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Without expressed written revocation this authorization will remain in effect from the date of signature.

Messages from Thirlby Clinic, PC:
May include: appointment confirmation and new prescriptions or refills that have been sent to your pharmacy.

I would like to receive these messages via: (We will use the numbers listed in your chart)

Primary #: ☐ Home # ☐ Cell # ☐ Work #
Secondary #: ☐ Home # ☐ Cell # ☐ Work #

Do you prefer a detailed message or a brief message asking you to call back?

☐ Leave full message (if greeting doesn't verify whom we are calling only a call back may be left) ☐ call back only

The Patient Portal gives you online access to your information and allows you to communicate with your doctor. You may ask any employee to activate your portal. Your email address is needed: _____

I understand that my medical records may contain reports, test results and notes that only a physician can interpret.

I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent misunderstanding of the information that has been written in the record.

Signature: _____ Date: _____/_____/_____

Yearly Verification of Information: (I have reviewed the above information and it is still accurate)

Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____

Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____

Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____ Initials: _____ Date: ____/____/_____

Office Use: eMessenger: _____ HIPAA: _____ Contacts Entered: _____