Great Lakes Physicians

Authorization for Release of Protected Health Information

I authorize the following GLP Provider(s):

___ Dr. Marc Naderer,MD ___ Dr. Max Pavlock, DO

___ Lisa Aichholz, CNP ___ Dr. Corey Fazio, DO ___ Dr. Gregory Karasik, MD

___ Dawn Bova, MSN, NP-C ___ Dr. Andrea Moore, MD ___ Dr. Nathan Fogt, DO

I authorize the following Provider(s)/Facility: _____

Phone: _____ Fax: _____

To release information from the record of:

_____ _____ _____ as described below to:

Patient Name DOB SS#/MR#

_____ _____ _____

Facility / Person to receive records Phone # Fax #

_____

Address City State Zip Code

Records are requested for the purpose of:

___ Continuing Care/Medical Facility ___ Legal

___ Personal Use ___ Insurance

___ Other: _____

Mode of release: ___ Mail ___ Pick Up ___ Fax ___ Other: _____

Specific Information to be released (check all that apply):

___ Complete Chart ___ Operative Report ___ Progress Notes ___ Discharge Summary

___ Laboratory ___ Pathology Reports ___ Radiology ___ Medication Sheets

___ Consultation Notes ___ Obstetrical Records ___Itemized Bill ___ Work Related Injury Notes

___ Other: _____

HIV and Mental Health Information contained in the parts of the records indicated for release will be released through this authorization unless otherwise indicated. Do not release: ___ Drug/Alcohol ___ HIV ___ Mental Health (Psychiatric)

I understand that this authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No timeframe may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: _____

_____ _____

Patient Signature Date Signature of Authorized Representative (Appropriate paper work required)

___ Parent or Legal Guardian ___ Power of Attorney

___ Executor of Estate

Revised: 3/13/17