



**Roy B. Parke, D.O.  
And Associates**  
1045 East Front Street  
Buchanan, MI 49107  
(269) 695 - 5540

*About your request for copies of your medical records ...*

To assist you in understanding the process for obtaining information from your medical record, we would like to share the following information with you:

1. While information contained in your medical record is your information, the physical chart remains the property of the medical office. The medical office must retain this original record for a variety of reasons including but not limited to situations such as insurance company audits, requests for information for legal proceedings, and so forth. Therefore, you may not obtain the original chart - but you can obtain a copy of the original chart.
2. When you desire a copy of your medical record, we ask that you use only our release form for your request. This ensures that our handling of your records is in harmony with current HIPAA confidentiality and security laws. Our form has been reviewed by our health law attorney and we have been assured that it is in harmony with HIPAA laws.
3. Furnishing you with a copy of your chart incurs certain expenses to us - expense is involved for staff time, for copying machine functions, for the paper, and for the postage if the records are being mailed. Therefore, we do charge a fee for copies of your record – this is permitted by Michigan law and the law sets the rates that we are allowed to charge. Our medical records staff can give you an estimate of the fee for a copy of your medical record. Fees must be paid prior to the copying of your medical record. Michigan law allows us to withhold copies of the medical record until payment has been made. The only exception is if you are considered to be indigent – in which case you must provide appropriate proof of your indigent status and you are limited to one set of records which are received free of charge.
4. If your objective is to furnish copies of your chart to someone other than yourself (for instance another physician, a hospital, an attorney, etc.) then you should consult with them first to see if they desire to request the records be sent to them directly. When records are given directly to a patient, we stamp each record with a stamp that states that the record was released directly to the patient. There are situations where other entities will not accept those records because they haven't been received directly from us. Determining ahead of time the method for releasing your records will help reduce the possibility of you needing to pay for multiple record releases. If we release records to an entity other than yourself then there is an additional fee as allowed by Michigan law. Our medical records staff can advise you as to how much the additional fee is under current Michigan law.
5. Copying a medical record can be quite time consuming – especially if you are a long-standing patient of our office or if you have had a complicated health history. Therefore, we do need sufficient time to process your request. We strive, in most cases, to accommodate requests within 1 week of an approved, signed request. In some instances, however, if we have staff out on vacation or for various other reasons, it may take a longer period of time. Michigan law does allow us a longer period of time to accomplish the task.

I have read the above information and understand that this is the process that will be followed.

Signed \_\_\_\_\_ Date \_\_\_\_\_



Roy B. Parke, D.O.  
And Associates  
1045 East Front Street  
Buchanan, MI 49107

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**NOTE:** This consent cannot be honored unless COMPLETELY filled out. To ensure prompt processing, read carefully and fill in ALL appropriate spaces, including your signature and a witnessing signature.

**Patient Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Address** \_\_\_\_\_

**I hereby authorize Buchanan Family Medical Center to use or disclose the following protected health information, which may include:**

- Alcohol and drug abuse records as protected under the regulations in Title 42 of Code of the Federal Regulations, part 2.
- Any records pertaining to communicable disease or serious communicable disease and infections as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis B, HIV, AIDS, and ARC) and (specify other, if known) \_\_\_\_\_.
- Mental health records, psychological service records, social service records including communications made by me to the social worker or psychologist.
- Records pertaining to obstetrical care or family planning.

**For Date(s):** \_\_\_\_\_

**Information to be disclosed (check all desired):**

- Complete chart
- Progress notes
- Immunization record
- Lab, EKG, X-ray reports (specify) \_\_\_\_\_
- Physician/Provider completed form for \_\_\_\_\_
- Employment or school physical exam dated \_\_\_\_\_
- Information received by Buchanan Family Medical Center from \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**Purpose of disclosure:**

- Continuing care
- Personal use
- Attorney/legal
- Transferring completely out of this practice to another physician
- Other \_\_\_\_\_

**Disclose to the following party:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(continued...)

1045 East Front Street, Buchanan, MI 49107 Phone: 269.695.5540 Fax: 269.695.0412  
www.buchananfamilymed.com

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Buchanan Family Medical Center, Attn: Privacy Officer  
1045 East Front Street, Suite A, Buchanan, MI 49107

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. Without express revocation, this consent expires 90 days after the signature date set forth below or for the following specified reasons:

- A) Event: Completion of forwarding records to above named party
- B) Condition: \_\_\_\_\_

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further understand that information released is for the specific purpose stated above and Buchanan Family Medical Center cannot attest to the accuracy of re-release of this information. I further understand that Buchanan Family Medical Center cannot attest to the accuracy of information that they have received from other health care providers. For that reason, Buchanan Family Medical Center strongly encourages patients to obtain copies of information directly from the originating provider.

Check One of the Following:

- I understand that the practice will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that the health care provided by the Practice is solely for the purposes of creating protected health information for \_\_\_\_\_ and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the practice will not provide health care services to me.

I understand that I have the right to: 1) inspect or to obtain a copy of my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or 2) to refuse to sign this authorization.

I understand that a reasonable fee may be charged for the copying of records, and I am responsible for that charge. As the patient, I am responsible for all charges from medical facilities for medical records transferred to Buchanan Family Medical Center. A photo static/faxed copy of this authorization shall be considered as effective and valid as the original. I have read or have had read to me this consent form and understand what it means.

_____ Patient/Legal rep signature	_____ Patient/Legal rep printed name
_____ Consenting party relation to patient	_____ Witness signature
_____ Date	_____ Time
_____ Patient/Legal rep phone number	

**To Be Completed By Buchanan Family Medical Center:**

(A copy of the signed authorization should be provided to the patient. If this authorization is being requested by BFMC for its own purposes, BFMC **must** provide the patient with a copy of the signed authorization.)

Chart # _____	Date received _____	Received by _____
# of pages _____	Date disclosed _____	Disclosed by _____
Charge \$ _____	Payment date _____	

Notes regarding information disclosed: \_\_\_\_\_  
\_\_\_\_\_