Northern Lights Family Medicine
9883 Business US 31 North
Montague, MI 49437

Phone: 231-893-6363
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Jacob Sauve, PA-C
Colin Rabach, PA-C

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Sex _____

Address _____ City _____ ZIP _____ Phone _____

Insurance Information

Primary Insurance _____ Member ID _____ Group _____

Secondary Insurance _____ Member ID _____ Group _____

☐ I authorize Northern Lights Family Medicine to **RELEASE INFORMATION TO**:

_____

Name of Doctor Address Phone

☒ I authorize the organization named below to **RELEASE INFORMATION TO NORTHERN LIGHTS FAMILY MEDICINE:**

_____

Name of previous Provider Phone Fax

Date range 3 years OR ☒ All Medical Records

**** IF PATIENTS RECORDS ARE MORE THAN 50 PAGES PLEASE MAIL TO THE ABOVE ADDRESS****

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with HIV. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, except to the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires, as noted below.
Other Rights: I understand I may refuse to sign this authorization and that my refusal will not affect the use or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
Signature of Patient or Legal Representative:
Date
If signed by Legal Representative, Relation to Patient:

****Once your records are received and reviewed by Jake and Colin, you will receive phone notification of acceptance. If you are not accepted as a patient you will have 30days from the time you were notified to pick up your records from our office or they will be destroyed.****

HOW DID YOU HEAR ABOUT OUR OFFICE? _____