GMP Network
For Physicians, By Physicians

Care Management Release of Health Information

Please Print:

Patient Name_____MRN_____D.O. B_____

Name of Primary Care Physician/Referred Provider_____

Name of Parent (if minor child) Legal Guardian or Power of Attorney_____

Care Management Partnership Definition(s):
GMP Network Care Management Team will work with the above listed Provider to accomplish Health goals to achieve the best possible Health outcomes for your chronic conditions(S). These Health goals and all elements to be discussed and achieved are to be set forth, approved, and put in place at the direction of your Primary Care Physician. As a member of your care management team, we support the ***Patient-Centered Medical Home-Neighborhood*** model, designed to work with you and your primary care physician to ensure you achieve the best health outcomes. A dedicated care manager will work with you to develop a customized plan to maintain and/or achieve your health care goals. Any changes to these goals will be at the discretion of the Primary Care Provider **only.** GMP Network Care Coordinators will work to support and educate on these goals and health outcomes. As an important element to the process, all appointments set forth and recommended by the PCP must be kept by the patient. Care Management services are in no way a replacement for any in-person required and recommended appointments with your PCP. Lack of adherence to these requirements may lead to the discontinuation of services with GMP Network. ****This signed release must be completed and mailed back in the enclosed stamped addressed envelope prior to any information being released and or discussed with any individuals other than yourself.***

Release of Health Information:

* **The names listed here are the ONLY individual's (other than yourself) information will be released to and discussed. This complies as set Forth with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information can be released in Verbal form.**

Please Print:

Name_____Relationship_____

Name_____ Relationship_____

Name _____Relationship_____

Please select a choice for each of the following:

Complete Health Record	**Include☐**	**Exclude ☐**
Behavioral/Mental Health Record	**Include☐**	**Exclude ☐**
Substance Abuse Record	**Include☐**	**Exclude ☐**
Domestic Relationships	**Include☐**	**Exclude ☐**
Sexual Orientation	**Include☐**	**Exclude ☐**

Other records as indicated by patient_____

By signing this form I am attesting to the fact that the records I am requesting be released, and may include alcohol, substance abuse, mental health status, and serious infectious and communicable diseases (including venereal diseases, tuberculosis, Hepatitis C, and HIV infection)2 are protected under State of Michigan and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that I may revoke this authorization in writing at any time and that this authorization pertains to fulfillment of the above stated request. No information collected beyond this date will be released unless it pertains to this request. This release expires one year from the date of signature. I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I DO HEREBY CONSENT TO THE DISCLOSURE OF THE ABOVE-DESCRIBED INFORMATION CONTAINED IN THE HEALTH RECORD IDENTIFIED ON THIS FORM

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Date: _____
PATIENT / MINOR'S PARENT / GUARDIAN / MEDICAL POWER OF ATTORNEY SIGNATURE_____

Date: _____
WITNESS Printed Name _____Witness Signature_____

1 Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose (21 USC 1175; 42 USC 4582). 2 Michigan Public Health Code (MCL 333.1101 et seq.); Medical Records Access Act (MCL 333.26261 et seq.). 2014-2015 Appropriation Bill.