



133 S. Main St. Mt. Clemens, MI 48043 (586) 465-1326

30795 23 Mile Rd., Ste 201 Chesterfield Twp., MI 48047 (586) 421-1600

AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS INFORMATION

TO: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the above listed entity to [ ] release [ ] receive my protected health information.

I hereby authorize use or disclosure of the named individual's Protected Health Information (PHI) as described below:

Form with fields for patient name, date of birth, Social Security number, address, telephone number, treatment dates, and purpose of request.

The following information is to be disclosed:

(Please check one box for each item requested - if "complete record" is indicated, no further boxes need to be checked off)

Grid of checkboxes for disclosure items: COMPLETE RECORD, cardiac, physician/office notes, tests, lab results, x-ray reports, history & physical, other.

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 the Human Immunodeficiency Virus (HIV).

- I do not authorize the release of records regarding HIV infection, AIDS related Complex, and/or serious communicable diseases.
I do not authorize the release of records regarding drug/alcohol abuse

redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

- a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: (If I do not specify an expiration date, event or condition, this authorization will expire in one year).

Signature and Date fields for patient/legal representative and witness, plus a field for relationship to patient.

REVOCACTION SECTION: I hereby revoke this authorization: