AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

Information Requested (please check appropriate box(es)

Dates of Service:_____

- ☐ History and Physical
- ☐ Audiology Reports
- ☐ Progress Reports
- ☐ X-Ray/MRI's
- ☐ Laboratory Reports
- ☐ Discharge Summaries
- ☐ All Medical Records
- ☐ Other:_____
- ☐ Pathology Reports
- ☐ Surgery Reports

As the Legal Representative identified below, I hereby authorize and request the health information as indicated in the section above, be sent to or received from:

FROM: _____ TO:_____

_____ _____

_____ _____

I or my personal representative authorize the release of information in my health records including: information about Human Immune Deficiency Virus Positivity (HIV +), Acquired Immune Deficiency Syndrome (AIDS), and AIDS related complex, as defined by the Michigan Department of Public Health. Along with Alcohol and Drug abuse treatment information as protected under the regulations in CFR 42, Part 2.

The purpose for the use or disclosure of the above referenced health information is for:

- ☐ Patient's personal use
- ☐ Transferring of care to another physician
- ☐ Legal Purposes
- ☐ Disability Claims
- ☐ Insurance Purposes
- ☐ Other:_____

You have the right to revoke this authorization in writing consistent with the terms of the Notice of Privacy Practices provided to you and available in our office;

We may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization;

You understand that there is the potential for information disclosed with this authorization to be subject to re-disclosure by the recipient;

This authorization shall expire 3 years from the date noted below, unless a shorter time span is requested.

_____ _____

Patient Name/ *Patient's Personal Representative Date

_____

*The relationship of the personal representative to the patient