Mid-Michigan ENT | ALIGN ENT+ Allergy Partner

Authorization for Release of Medical Information

Patient Name _____ Date of Birth _____

Address _____ Phone _____

Information Requested: [please check the appropriate box(es)]

- ☐ All Verbal and Written Medical Information
- ☐ All Verbal Medical Information
- ☐ All Physical/Electronic Information
- ☐ Physical/Electronic Copies of Medical Information for Date(s) of Service _____
  - ☐ History and Physical
  - ☐ Laboratory Reports
  - ☐ Pathology Reports
  - ☐ Audiology Reports
  - ☐ Surgery Reports
  - ☐ X-Ray/MRIs
  - ☐ Progress Reports
  - ☐ Treatment Summaries
  - ☐ Discharge Summaries
  - ☐ All Medical Records
  - ☐ Other _____

☐ Mail ☐ Pick Up ☐ Encrypted Email* _____ ☐ Fax _____

**If requesting records sent to email, please be advised that it is not always secure.*

I hereby authorize the health information to be disclosed to the below parties:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

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 (ARC), as defined by the Michigan Department of Public Health, along with alcohol and drug abuse treatment information, as protected under the regulations in 42 CFR Part 2.

You have the right to revoke this authorization in writing in a manner 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 based on whether you sign this authorization.

You understand that the information disclosed with this authorization may be subject to redisclosure by the recipient.

This authorization will not expire unless revoked in writing.

_____ _____

Patient Signature or Print Name of Patient's Personal Representative **Date**

_____ _____

Authorized Representative Signature Office Use: Patient MR#