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INFORMED AUTHORIZATION/CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE ______________________________ TO RELEASE THE MEDICAL RECORDS OF

____, BIRTHDATE ________________________,
(PATIENT'S NAME)

ADDRESS____, PHONE # ____________.

Reason for request ☐ Transferring Care ☐ Personal Use ☐ Other ____________

Records requested ☐ Complete Record ☐ Other ______________________

RELEASE TO: ______________________________ ______________________________ ______________________________ ______________________________

OBTAIN FROM: ______________________________ ______________________________ ______________________________ ______________________________

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the privacy officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. I understand I have the right to refuse to sign this authorization or to inspect or copy my protected health information to be used or disclosed as permitted under federal and state laws. cable State of Michigan and Federal laws. I understand these records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or substance abuse counseling, and/or HIV/ARC testing. I understand the practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient any may no longer be protected by federal or state law. Without expressed written revocation, this consent expires after one year.

DATED THIS ____________________ DAY OF ____________________, 20 ______

______________________________ ______________________________

SIGNATURE OF PATIENT/GUARDIAN SIGNATURE OF WITNESS

Office Use Only

Sent By: ______________Date________ Faxed ☐ Mailed ☐ Picked Up ☐