

322560MH (08/13)

321

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (NOT FOR PSYCHOTHERAPY NOTES)

Patient Name	nt Name		Date of Birth/	
Social Security #	Maiden / Other Name			
Patient Address				
Street	City	State	Zip	
Phone Number				
l authorize	······································			
Healthcare facility / p to release information contained in my me information about substance abuse treatments.	edical record (including if applicable and information about mentation)	l health services)	HIV infection or AIDS,	
Name to whom information may be releas			4000 FOF 4	
P.O. BOX 5054	SOUTHFIELD	MI	48086-5054	
Address	City	State	Zip Code	
(248) 357-3330	(248) 357-3337			
Area Code Telephone Number	Fax Number			
Date(s) of Treatment:		·		
☐ History & Physical ☐ X-Ray Image ☐ Consultations ☐ Operative Re ☐ Laboratory Results ☐ Pathology Re The Purpose and Need for Such Disclosure	eports Other(specify): _{PLEASI}			
The Purpose and Need for Such Disclosur	e	· · · · · · · · · · · · · · · · · · ·		
For mental health records, or records pertagonal as to how the information to be disclosed in				
I understand that I have a right to revoke to must do so in writing and present my writte have already released the information base after we receive your revocation. We will re authorization unless otherwise allowed by	en revocation to the Health Informed en revocation to the Health Informed en grant e	nation Management [We will not release a	Department. We may any additional information	
Your protected health information will be days from the date of signature, or until we information could be subject to re-disclosure.	e have completed the disclosure(s) you've requested,	whichever is shorter. This	
Signature of Dationt / Daront / Darconal Da			// 	
Signature of Patient / Parent / Personal Re				
If you are signing as a parent, guardian, o source of your authority to sign this form be	•	patient, describe this r	elationship and the	
Relationship to Patient	Print Nar	ne		
Source of Authority				