	CHM DRH HTZ	☐ MBHS ☐ RIM ☐ SGH
Detroit Medical Center Wayne State University	HUH HVSH	TCH TOSH

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(NOT FOR PSYCHOTHERAPY NOTES)

Patient Name		Date	Date of Birth X		
Social Security #X					
Patient Address					
S	treet		City	State	Zip
Phone Number	······- <u></u>	<u>,, , , , , , , , , , , , , , , , , , ,</u>			•
I authorizeREHABILIT	ATION INSTITUTE O	F MICHIGAN	to release informat	tion contained in my	medial
		cility /physician			
record (including if appliinformation about mental	icable, information about la la health services)	HIV intection or AIDS	, information about substa	ance abuse treatme	nt and
Name to whom informat	י. רכד	ECORDS DEPOSIT	ION SERVICE		·
P.O. BOX 5054, S	OUTHFIELD, MI 480	86-5054			······································
Address		City	State	Zip Code	
248	357-3330				
Area Code	Telephone Numbe	9r 		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Charles Trope of indepen					
Discharge Summary	nation To Be Disclosed:	🛛 Other (Sp	ecify) ENTIRE MEDICA	L FILE.	
☐ History & Physical	☐ X-Ray Films	······································			
□ Consultations	□ Operative Report				
☐ Laboratory Results	☐ Pathology Report	Date(s) of T	reatment		
	is, or records pertaining to		S, the above paragraph m	ust include a statem	ent as to how
the information to be dis	sclosed is relevant to the p	urpose and need for	such disclosure.		
so in writing and preser released the information	a right to revoke this authors my written revocation to based on your original arcondition treatment or payw.	the Health Information the Health Information. We will	on Management Department not release any additions	ent. We may have a Il information after w	lready e receive your
the date of signature, or	formation will be disclose until we have completed ure by the recipient and m	the disclosure(s) you	ive requested, whichever		
Signature of Patient/Par	ent/Personal Representati	ive	Date		·
If you are signing as a pauthority to sign this for	arent, guardian, or persor m below.	nal representative of	the patient, describe this i	relationship and the	source of you
Relationship to Patient		······································	Print Name		<u></u>
Source of Authority			······································	· ····································	