Macomb Physicians Group, PLLC
8244 Metro Parkway
Sterling Heights MI 48312

Phone (586) 795-4060 Fax (586) 795-5596

Authorization To Use Or Disclose Medical Information

(Medical Records Release)

Patient Name: _____

Date of Birth: _____/_____/_____ Phone Number: _____

Patient Address:_____
Street City State Zip Code

I authorize _____ (Healthcare facility/physician) to release the protected health information (PHI) described below. Unless specifically excluded, the PHI may include information about: alcohol and drug abuse treatment, behavioral or mental health services and/or communicable diseases and infections, such as sexually transmitted diseases, AIDS and HIV.

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

RELEASE TO:

[] Self

[] Macomb Physicians Group, PLLC (address above) Attn: Doctor: _____

[] Facility/Doctor's Name: _____

Address:_____
Street City State Zip Code

Phone: _____ Fax: _____

SPECIFIC TYPE OF INFORMATION TO BE RELEASED:

[] Entire medical record

[] Visit notes for dates of service: _____

[] Labs/Reports for dates of service: _____

[] X-rays for dates of service: _____

[] Other: _____

Exclude: [] Substance Abuse [] Mental Health Conditions [] Sexually Transmitted Diseases [] HIV/AIDS

PURPOSE AND NEED OF SUCH DISCLOSURE:

[] Concurrent Care [] Transfer of Care [] Other:

AUTHORIZATION:

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Once health care information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy laws.

_____ _____
Signature of Patient / Parent / Personal Representative Date

Relationship to Patient: _____ Print Name: _____