1308 South Main Street
Plymouth, MI 48170
Phone: (734) 451-3440
Fax: (734) 451-8720

AUTHORIZATION TO RELEASE AND/OR OBTAIN COPIES OF A CLINICAL MEDICAL RECORD

For Office Use Only:
Information:
☐ Mailed ☐ Picked Up ☐ Faxed

Date Received: _____
Date Processed: _____
Processed By: _____

I legally authorize KaraLee & Associates, P.C. to release protected health information about me/my child to the recipient listed below.

☐ IHA Office

PATIENT:

Patient's Name

Patient's Address

City, State, Zip Code

Patient's Date of Birth Phone Number

RECIPIENT:

Self or Name of Physician, Institution, Clinic, Company, etc.

Address/Suite Number

City, State, Zip Code

Phone Number Fax Number

INFORMATION TO BE DISCLOSED:	PURPOSE(S) FOR WHICH THE INFORMATION MAY BE DISCLOSED:
☐ Initial Clinical Assessment	☐ At the Request of the Patient
☐ Quarterly Review(s)	☐ Continuation of Care/Transfer of Care
☐ Psychiatric Evaluation	☐ Attorney/Legal
☐ Medication Log	☐ Social Security/Disability Certification
☐ Discharge	☐ Insurance Company
☐ Other:	☐ Worker's Compensation
	☐ VIEW ONLY: (Documents will not be printed or sent)
	☐ Other:

TO OBTAIN PATIENT INFORMATION FROM ANOTHER HEALTH ORGANIZATION:

☐ I authorize the release of information from:

Self or Name of Physician, Institution, Clinic, Company, etc.	Phone Number	Fax Number
Address/Suite Number	City, State, Zip Code	

EXPIRATION: (may be a specific date or a condition; if left blank, expires 6 months from date below):

This authorization expires: _____

REVOCATION (cancelling) & REDISCLOSURE:

REVOCATION (cancelling): I may revoke (cancel) this authorization at any time. Revocations (cancellations) must be made in writing. After it is revoked, KaraLee & Associates, P.C. will make no further disclosures to the above persons without a new authorization.

REDISCLOSURE: Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws.

SIGNATURE: _____ Print: _____ Date: _____
(Patient, Parent, Legal Representative)

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.

Payment: There will be fees associated with most record requests. The fees are outlined on attached page.

HOW TO OBTAIN COPIES OF MEDICAL RECORDS

Records can be released to anyone that the patient authorizes (in writing) to receive such information.

REQUESTING MEDICAL INFORMATION ON BEHALF OF SOMEONE OTHER THAN YOURSELF:

If you are requesting medical records for someone other than yourself, you will be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents may include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc.
Requests for medical records of deceased patients require a letter of authority in addition to your signed request. The letter of authority is given to the executor of a person's estate by the Probate Court upon their death.

FEES:

For continuation of care, medical records sent from KaraLee and Associates, P.C. to another medical office are free of charge.
Some records requested for legal, insurance, or personal use may require a prepayment. If your request requires prepayment, a fee notice will be given to you. Actual postage will be added to the fees outlined below (if applicable). Records fees will be billed as follows:

Patients:
Pages 1-20: $1.53 per page
Pages 21-50: $0.77 per page
Pages 51 and up: $0.31 per page

Attorneys & Insurance Companies:
Initial Fee: $30.60
Pages 1-20: $1.53 per page
Pages 21-50: $0.77 per page
Pages 51 and up: $0.31 per page + Actual postage

KaraLee & Associates, P.C. accepts cash, checks, Visa, Mastercard and Discover. Please make checks payable to KaraLee & Associates, PC.