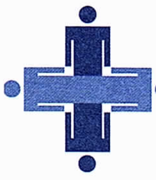

Partners in Family Medicine
6000 24 Mile Road
Shelby Township, MI 48316
PH 586.677.3310 FAX 586.677.3326

Gregory B. Koby, D.O.
Kristina Wixon, D.O.

Patient Name:______________________________________ Birth Date:______/______/______

Address:____

Social Security Number ______/______/______ Telephone Number: ____________________

I Authorize: ___________________________________ Fax:________________________

Phone:______________________

Address:____

To release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). This health information is referred to herein as "Protected Health Information."

To whom the information may be released: **Gregory B. Koby, D.O**. and/or **Kristina M. Wixon, D.O.**

Specific information to be disclosed: _____ All Records _____ Last Pap/Chlamydia and Mammogram

_____ Last Eye Exam _____ Colonoscopy _______ Last PSA _______________________Other

You have the right to revoke this Authorization except if action has already been taken in reliance upon this Authorization. You may revoke your Authorization by submitting a request in writing to: Partners in Family Medicine, PLLC 6000 24 Mile Rd., Shelby Township, MI 48316.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. FURTHER, I AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE TERMS OF THIS AUTHORIZATION.

Signature:____
Patient or Authorized Representative

Printed Patient Name:_________________________________

Date:______________________
Without expressed written revocation, this authorization expires **six months from request date**.