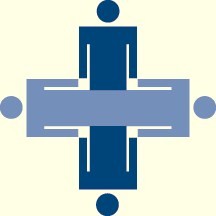
Gregory B. Koby, D.O.

Kristina Wixon, D.O.

Juli Grover, DNP

Lindsay Prusakiewicz, FNP-C



Partners in Family Medicine

6000 24 Mile Road

Shelby Township, MI 48316

586.884.6702 ph

586.677.3326 fax

**MEDICAL RECORDS REQUEST**

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) to **Partners in Family Medicine**. This health information is referred to herein as “Protected Health Information.”

Specific information to be disclosed: \_\_\_\_\_ All Records

Laboratory Results From: to

Diagnostic Imaging (X-ray, MRI, CT, Echo, Stress Test) From: to

\_\_\_\_\_ Most recent Pap and/or Mammogram \_\_\_\_\_ Most recent Eye Exam \_\_\_\_\_ Most recent Colonoscopy

\_\_\_\_\_Other

The purpose and need for such disclosure: Continuation of care

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 written request to: Partners in Family Medicine, PLLC 6000 24 Mile Rd., Shelby Township, MI 48316. This authorization expires 6 months from request date.

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.

Patient/Authorized Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_