Partners in Family Medicine
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# MEDICAL RECORDS REQUEST

Patient Name:_____________________________________________ Birth Date:_______/_______/______

Address:_________________________________________________________________________________

Telephone Number: ______________________

I Authorize:____________________________________ Fax: __________________ Phone: _____________

Address: ________________________________________________________________________________

To release health information identifying me (including if applicable, information about HIV infection or AIDS, substance abuse treatment, and information about mental health services) to **Partners in Family Medicine for continuity of care purposes**. 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____________________________________________________________________________

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:______________________