Partners in Family Medicine
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MEDICAL RECORDS REQUEST

Patient Name:_____ Birth Date:_____/_____/_____

Address:_____

Telephone Number: _____

I Authorize:_____ Fax: _____

☐ Corewell Health ☐ HFHS ☐ McLaren ☐ TCG ☐ Ctr Digestive Health ☐ Basha

Address: _____ Phone:_____

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."

Please send records via FAX 586-677-3326 if under 25 pages or mail to: 6000 24 Mile Rd, Shelby Twp MI 48316

Specific information to be disclosed: _____ All Records From: _____ To:_____

_____ Laboratory Results From:_____to_____

_____Diagnostic Imaging Reports (no PACS) _____

_____Last Pap/Mammogram Report _____Last Bone Density _____Last Eye Exam _____Last 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:_____