Partners in Family Medicine
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MEDICAL RECORDS RELEASE

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

Address:_____

Social Security Number _____/_____/_____ Telephone Number: _____

I authorize: Partners in Family Medicine, 6000 24 Mile Road, Shelby Twp., MI 48316 586-884-6702

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."

Name and address to whom the information may be released: Fax:_____

Name/Facility_____Phone:_____

Address:_____

Specific information to be disclosed: ___ All Records

_____ Laboratory results, specify test or date(s): From: _____To:_____

_____ Diagnostic Reports (x-ray, EKG, MRI, CT, etc.), From: _____ To: _____

_____ 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 request in writing to: Partners in Family Medicine, PLLC 6000 24 Mile Rd., Shelby Twp., MI 48316.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure 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**.