Authorization for Release of Medical Information for Medical Use

Main Center Family Medicine • 422 N. Center Street • Northville, MI 48167

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A Division of Envision Medical Group

Regarding Patient:

Name: (last, first):_____ **Date of Birth:** _____

Address:_____ **Telephone:**_____

City, State, Zip:_____

Records Released From:

Name:_____ **Telephone:**_____

Address:_____ **Fax:**_____

City, State, Zip: _____

Records Released To:

Name:_____ **Telephone:**_____

Address:_____ **Fax:**_____

City, State, Zip: _____

☐ **These records are needed for an appointment on:**_____

☐ **I would like to pick up a copy of my records. Please call me when available.**

Information to be released: (Check all applicable categories)

☐ **Complete Records** ☐ **Immunization Records** ☐ **Office Visit Notes**

☐ **Lab Reports** ☐ **X-ray reports/Disk ($5 charge for disk)**

In compliance with State and Federal Laws, special permission is required to release certain records. Please check the boxes below if you would like records released pertaining to:

☐ **Mental Health** ☐ **Developmental Disabilities** ☐ **Alcohol Abuse (Treatment/Evaluation)**

☐ **HIV/AIDS related illness.** ☐ **HIV Test results** ☐ **Substance Abuse (Treatment/Evaluation)**

Purpose or need for disclosure: (Check all applicable categories)

☐ **Continuation of Care** ☐ **Insurance /Claims** ☐ **Application for Insurance**

☐ **Legal** ☐ **Personal** ☐ **School Disability** ☐ **Academics**

☐ **Other:**_____

_____ _____

patient/parent/legal guardian/conservator name – signature **date**

_____ _____

patient/parent/legal guardian/conservator name – print **date**

_____ _____

witness name – signature **date**

_____ _____

witness name – print **date**