ALLEN PARK FAMILY PHYSICIANS AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

7445 Allen Rd. Suite 210 Allen Park Mi. 48101 **PHONE:** 313-388-9552 **FAX:** 313-789-7620

PATIENT NAME:________________________________ **DOB:**____/____/________

[ ] I AUTHORIZE ALLEN PARK FAMILY PHYSICIANS TO SEND A COPY OF MY RECORDS **TO:**
[ ] I AUTHORIZE ALLEN PARK FAMILY PHYSICIANS TO REQUEST MY RECORDS **FROM:**

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NAME OF PHYSICIAN HEALTH CARE FACILITY

____

STREET ADDRESS

____

CITY: STATE: PHONE #: FAX #:

INFORMATION TO BE RELEASED:

- ❑ ENTIRE MEDICAL RECORD MAY BE RELEASED
- ❑ IMAGING REPORTS (specify) ________________________________
- ❑ LABORATORY REPORTS (specify) ________________________________
- ❑ OPERATIVE REPORTS (specify) ________________________________
- ❑ PATHOLOGY REPORTS (specify) ________________________________
- ❑ HOSPITAL REPORTS (specify) ________________________________
- ❑ OTHER (specify) ________________________________

PURPOSE OF DISCLOSURE: [ ] Moved [ ] Insurance change [ ] Legal
[ ] Second Opinion [ ] FMLA [ ] Disability [ ] School [ ] Transfer from pediatric

1. I understand that this authorization will expire 60 days after i have signed the gorm.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by receipt and no longer be protected by Federal Privacy Regulations.
3. By authorizing this release of information, my health care and payment for my health care will not be affected if i do not sign
4. I understand that in compliance with state of Michigan laws pertaining to record copies, I may be charged a reasonable cost based fee ranging from $0.23 and $1.19 per page. There is no charge for medical records if copies are sent to facilities for specialist care, school purposes, insurance billing, or for Workers Compensation.

X____ ____________________

SIGNATURE OF PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON **DATE**