Advanced Urogynecology of Michigan P.C.
22731 Newman St., Suite 200
Dearborn, MI 48124

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patients Name:		Birthdate:
Street Address:		Telephone #:
City:	State:	Zip Code:

I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

TO RELEASE TO:

_____
Name of receiving person, persons/organization

_____
Street Address

_____
City State Zip Code

INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports

☐ Electrocardiogram (EKG) ☐ Allergy Records ☐ Immunization Records ☐ Other _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Signature:

If this release pertains to alcohol, drug, or mental health information, please not that this information has been disclosed to you from records protected by federal confidentiality rules (42 CR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RECORDS FROM THE PERIOD: _____ to _____

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal

☐ Personal ☐ Workers' Compensation Claim ☐ Other _____

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

Signature of Patient: _____ **Date:** _____