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 Southfield, Michigan 48075
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**AUTHORIZATION TO RELEASE
 PATIENT INFORMATION**
 (PATIENT OR REPRESENTATIVE REQUESTS
 INFORMATION TO BE SENT FROM OAKLAND
 REGIONAL)

FOR OFFICE USE ONLY:
 INFORMATION TO BE:
 MAILED PICKED UP FAXED
 ID VERIFIED: YES NO
 DATE RECEIVED: _____
 DATE PROCESSED: _____
 MRN: _____

THIS AUTHORIZATION IS VOLUNTARY. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.

PATIENT'S NAME: _____ DATE OF BIRTH: _____
 STREET ADDRESS: _____ TELEPHONE #: _____
 CITY/STATE/ZIP: _____ FAX #: _____

THIS INFORMATION IS TO BE DISCLOSED TO: SELF OTHER
 PLEASE PROVIDE INFORMATION IF OTHER (NAME, TITLE, ADDRESS, PHONE #, FAX #) BELOW:

HEALTH INFORMATION BEING REQUESTED (PLEASE CHECK ALL THAT APPLY):

- MRI/RADIOLOGY CD
- ABSTRACT - TO INCLUDE IF APPLICABLE (HISTORY AND PHYSICAL, DISCHARGE SUMMARY, OPERATIVE REPORT, CONSULT REPORT, LAB RESULTS, RADIOLOGY REPORTS, PATHOLOGY REPORTS)
- BILLING: ITEMIZED DETAIL
- INDIVIDUAL REPORTS: PLEASE SPECIFY: _____

PLEASE SPECIFY THE TREATMENT DATE OR TREATMENT DATES OF SERVICE BEING REQUESTED:

By signing this authorization:

- I understand that disclosure may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection< Acquired Immune Deficiency Syndrome or AIDS - related complex) and any other communicable disease.
- It may also include information about mental health service and treatment for alcohol and drug abuse as permitted by MCL 330.1748, 42CFR Part 2, P.A. 47 of 2004, and P.A. 368 of 1978.
- I understand that this authorization is voluntary. Oakland Regional Hospital/Oakland Nursing Center will not condition its treatment or payment of me based on signing this authorization.
- I understand that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the Federal Privacy Standards.
- I understand that I may revoke this authorization by notifying the Director of Medical Records for Oakland Regional Hospital in writing of my desire to revoke it. However, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that I have a right to receive a copy of this authorization.
- This authorization will automatically expire (6) six months from date of signature OR upon occurrence of the following event that relates to me or the purpose of the intended use or disclosure about me: _____
- I may request that certain information about me not be released to third parties. Information that I wish not be shared is as follows: _____
 Third parties I wish not to share this information with include: _____
- I UNDERSTAND THAT I MAY INCUR FEES FOR RECEIVING COPIES OF MY MEDICAL RECORDS. FEES FOR COPIES OF MEDICAL RECORDS ARE REGULATED BY THE STATE OF MICHIGAN

SIGNATURE: _____ DATE: _____
 PRINTED NAME: _____
 RELATIONSHIP TO PATIENT: _____