MEDICAL RELEASE OF INFORMATION/REQUEST FOR MEDICAL RECORDS

INFORMATION TO BE DISCLOSED

I authorize (previous doctor) _____, (city) _____, (state) _____, (phone number) _____, its agents and its employees to release protected health information about me to Dr. Rebecca Patrias, Dr. Sarah Bur, Dr. Deborah Peery and Laura Calamos, PhD FNP. This may include alcohol and/or drug abuse treatment, psychological and social work counseling, communicable disease or infections including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis, and demographic information for the purposes and under the conditions designed on this form.

Date of Request: _____ (this request is good for one year from the date of request)

Patient: _____

Address: _____

City/State/Zip: _____

DOB: _____

I _____, give my permission for the release of health information.

***Please include:

- Problem Summary List
- Most recent Laboratory tests plus PAP
- Consultation (referral) notes for the last year plus any colonoscopy reports
- X-ray reports for the last two years, plus most recent mammogram
- Other (please specify): _____

Please mail or fax immediately to:

Dr. Rebecca Patrias, Dr. Sarah Bur, Dr. Deborah Peery and Laura Calamos, PhD, FNP
350 N Main St Ste #100
Chelsea, MI 48118
Office: 734-433-1500 Fax 734-433-1400

Revocation: I understand that I may revoke my authorization. After it is revoked, the doctors will make no further disclosures to the above mentioned persons without a new authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

Re-disclosure: Once information has been disclosed, it may no longer be protected from further disclosure by federal or state privacy laws.

Conditioning of Eligibility: The doctors will not condition treatment, payment or eligibility on my signing this document.

Signature: _____ Date: _____