MACOMB PHYSICIANS GROUP, PLLC
8244 METRO PARKWAY STE C
STERLING HEIGHTS, MI 48312
P| 586-795-4060
F|586-795-5596

Authorization To Receive Or Release Medical Information

Attn: Medical Records Dept.

I Hereby Authorize:

☐ Macomb Physicians Group

☐ Facility / Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # : _____ Fax: _____

To Release:

☐ Complete Chart Record *(does not include billing information or radiographic images)*

☐ Chart Notes: ☐ All ☐ Specify: _____

☐ Labs / Reports: ☐ All ☐ Specify: _____

☐ Billing Records: ☐ All ☐ Specify: _____

☐ X-rays/Radiographic Images *(there may be a charge for this service)* Specify: _____

☐ Other: _____

From the Health Records of:

Name: _____ Date of Birth: _____

Social Security Number: _____ Daytime Phone: _____

Are you authorizing the release of your own records: ☐ Yes ☐ No

If not, what is your name and relationship to the patient?

Name: _____ Relationship: _____

To be Released to:

☐ Macomb Physicians Group

☐ Self (please indicate mailing address below)

☐ Facility / Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # : _____ Fax: _____

For the Purpose of:

☐ Concurrent Care ☐ Transfer of Care ☐ At my Request ☐ Other: _____

My Rights:

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(s) below to **EXCLUDE** the information from authorization):

☐ **substance abuse** ☐ **mental health conditions** ☐ **sexually transmitted diseases** ☐ **HIV/AIDS**

I understand that once health care information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy laws.

Patient Signature: _____ Date: _____

Rep./Guardian Signature: _____ Date: _____