Authorization to Release Protected Health Information

Patient Name _____ Social Security Number _____

Street Address _____ DOB _____

City, State, Zip _____ Phone _____

I hereby give the following entity permission to release my Protected Health Information (PHI):

_____

My Protected Health Information may be released to:

ADVANCED PHYSICAL MEDICINE
Name of Person/Organization
24345 HARPER AVE. ST. CLAIR SHORES, MI 48080
Address
586-563-3300 Phone **586-563-3313** Fax

I instruct the above named entity to produce the following information: (check ONE only):

____ Release a 2 year abstract of records ____ Entire Record

____ Release specific records

- ☒ Office Notes/Evaluations
- ☒ Physical Therapy Notes/Evaluations
- ☒ MRI reports
- ☒ Other urine drug screening
- ☒ X-ray reports
- ☒ EMG Studies
- ☒ CT Scan reports

This authorization expires one year from the date of signature. I am requesting my PHI to be disclosed for the following purpose: continuation of care
HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above *are to be released through this authorization* unless specified below.

DO NOT RELEASE: (Check all that apply) ____HIV____ Behavioral Health____Drug/Alcohol

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance to sign this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to signed this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information issued for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

X _____ X _____
Signature (Patient) Date

_____ _____
Signature (Patient Representative or Parent/Guardian) Date