

Professional Record Service

10524 Grand River Ste 101

Brighton, Michigan 48116

Phone: 810-229-8238

Fax: 810-229-5789

MEDICAL AUTHORIZATION

I, _____ / _____ / _____ hereby
(Patient Name) (Birth Date) (Social Security No.)
authorize _____
(Hospital/Doctor/Provider Name)

its designee or Medical Record Department, to release any and all records which may be requested regarding my past or current physical condition and treatment rendered, including but not limited to: alcohol and drug abuse records protected under the regulations in Title 42 of the Code of Federal Regulations Part II, if any; psychological services records, social services records, psychiatric services records, including communications made by me to a social worker, psychologist or psychiatrist. I also authorize release of records pertaining to Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), if any; communicable disease and serious communicable disease, infections and serious infections, venereal diseases, tuberculosis, hepatitis B records, if any, made confidential in rules promulgated by the Michigan Department of Public Health pursuant to Public Act 174 of 1989 of the Michigan Health Code.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED:

Discharge Summary ___ X-Ray Reports ___ Other: (specify) _____
History, Physical ___ X-Ray Films ___ _____
Consultations ___ Operative Report ___ _____
Laboratory Results ___ Pathology Report ___ Dates of Treatment: _____

PURPOSE AND NEED FOR SUCH DISCLOSURE: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

RECORDS SHALL BE RELEASED TO: **PROFESSIONAL RECORD SERVICE, LTD.**

10524 Grand River, Ste. 101

Brighton, Michigan 48116

Or _____

No other disclosure is authorized by this consent form. Professional Record Service, Ltd. is not liable for damages as the result of an unauthorized disclosure. A photocopy of this document shall be considered as valid as if the original were offered.

Signature of Patient Date Signed

Signature of Parent/Guardian/Personal Representative

Relationship to Patient _____ Source of Authority _____

Subscribed and Sworn to Before me this _____ day of _____, 200__

Name: _____

Notary Public, _____ County

My Commission Expires: _____