2300 Biddle Ave, Suite 100, Wyandotte MI 48192 • Phone 734-246-5705 • Fax 734-638-0020

Authorization to Release/Receive Medical Information

I authorize the named health care provider to release or receive information or records specified to this document upon request.

Patient Name: ______________________________

DOB: ______________________________

This information will be used for the purpose of:

- ☐ Continuation of care
- ☐ Providing advocacy services
- ☐ Investigation of abuse allegations
- ☐ Legal representation
- ☐ Other ______________________________

Physician Releasing Records: (Previous Physician)

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Physician/Patient Receiving Records

Downriver Medical Associates

2300 Biddle Ave, Wyandotte MI 48192

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Records Authorized to be Released or Sent:

- ☐ Entire Medical Record
- ☐ Office
- ☐ Lab Reports
- ☐ Radiological Images
- ☐ Consultations Notes
- ☐ Psychiatric and other mental health records
- ☐ Records related to drug or alcohol abuse
- ☐ Other: ______________________________
- ☐ Admission history and physical
- ☐ Discharge Summary
- ☐ Complete hospital chart
- ☐ Outpatient Records
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other information relating to my care
- ☐ Complaints or grievances filed, with responses or dispositions

I understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulation will no longer apply to the information disclosed, and that Downriver Medical Associates may share this information if needed.
- I am entitled to receive a copy of this authorization upon request.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Signature: ______________________________ Date: ______________

Print Name: ______________________________ Relationship to Patient: ______________

Witness: ______________________________