



STATE OF MICHIGAN  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 LANSING

RICK SNYDER  
 GOVERNOR

NICK LYON  
 DIRECTOR

AUTHORIZATION FOR THE MEDICAL RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Last 4 digits of SSN (if available): \_\_\_\_\_

Previous Name (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- PURPOSE OF DISCLOSURE. As part of my participation in an MDHHS sponsored health information collection study, I authorize this release.
- FEEs. I understand that as the patient I will not be responsible for any fees. Medical record request fees should be discussed with the receiving party.
- SENDING FACILITY. I authorize the facility specified below to disclose the health information described below

Facility Name \_\_\_\_\_ Physician Name \_\_\_\_\_  
 Facility Address \_\_\_\_\_ Intersection/Cross Streets \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Facility Phone \_\_\_\_\_

- RECEIVING PARTY. Please mail or fax my health information to:

**Dr. MARY GRACE BRANDT**  
 27725 GREENFIELD RD OFFICE 57A  
 SOUTHFIELD, MI 48076  
 248-424-7913 PHONE  
 248-424-9161 FAX

- DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED.

**\*\*Requesting ALL documentation from \_\_\_\_\_ through the \_\_\_\_\_\*\***

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| <ul style="list-style-type: none"> <li>Demographic cover sheets (Name, DOB, gender, race, insurance)</li> <li>Progress notes</li> <li>Consultation notes</li> <li>History and physical exam notes</li> <li>Laboratory results</li> <li>Pap smear reports</li> <li>Mammogram reports</li> <li>Vaccinations and PPD records</li> </ul> | <ul style="list-style-type: none"> <li>Medical history summary sheets/flow sheets</li> <li>List of diagnoses/Problem lists</li> <li>Current medication lists</li> <li>Procedure notes</li> <li>Hospital admission and discharge summaries</li> <li>Social worker and case manager notes</li> <li>Pregnancy records</li> <li>Radiology reports</li> </ul> |
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- EXPIRATION OF AUTHORIZATION. Unless I request in writing otherwise, I understand that this authorization will expire on May 31, 2017.
- RIGHT TO REVOKE AUTHORIZATION. 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. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.
- RELEASE AND WAIVER. If the health information that I have requested the sending facility to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome, human immunodeficiency virus, venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party authorized above. I also release the sending facility and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date