



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
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
3044 W. GRAND BLVD, STE. 3-300
DETROIT, MI 48202
313-456-1586 PHONE
313-456-1585 FAX

- DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED.

****Requesting ALL documentation from _____ through the _____ ****

- Demographic cover sheets (Name, DOB, gender, race, insurance)
- Medical history summary sheets/flow sheets
- Progress notes
- List of diagnoses/Problem lists
- Consultation notes
- Current medication lists
- History and physical exam notes
- Procedure notes
- Laboratory results
- Hospital admission and discharge summaries
- Pap smear reports
- Social worker and case manager notes
- Mammogram reports
- Pregnancy records
- Vaccinations and PPD records
- Radiology reports

- EXPIRATION OF AUTHORIZATION. Unless I request in writing otherwise, I understand that this authorization will expire on May 31, 2021.
- 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 _____