

Patient Authorization to Release Health Information

Patient Name: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Phone: _____

I request that my protected health information (PHI) from this facility be disclosed to:

SELF ☐ OTHER ☒ (Provide recipient information below)

Recipient Name: Legal-Ease Digital Imaging

Address: 2496 Meadowcroft Dr City: Burton State: MI Zip: 48519

E-mail: pat.legalease@gmail.com Phone: 855-543-4003

Fax: (healthcare provider/facility only) 810-547-4030

I authorize the following protected health information to be released from my medical record(s):

(PLEASE CHECK ALL THAT APPLY):

- ☐ Laboratory Reports
☐ Radiology Reports
☐ Pathology Reports
☐ Imaging Studies (provided on CD or DVD)
☒ Abstract/Summary (Includes if applicable, History & Physical, Discharge Summary, Operative Report(s), Consultations, Test Results and Radiology Reports)
☐ Itemized Billing Records
☐ Specific Report(s): _____

Please indicate the period of healthcare: Specific Date(s): _____ to _____
OR ☐ All Encounters/Visits

Disclosure Format (Paper is default if not marked):

☐ U. S. Mail -paper format ☒ Fax (healthcare provider/facility) ☐ E-mail ☒ CD/DVD/ Flash Drive ☐ Pick-Up

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 22401 Foster Winter Dr. Southfield, MI 48075. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire (6) months from date of signature. Or upon the occurrence of the following date/event/condition: _____
- My health record may include information relating to sexually transmitted disease(s) (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by the Federal Privacy Standards.
- I may request that certain information about me not be released to third parties. Information that I wish not be shared is as follows: _____
Third parties I wish not to share this information with include: _____
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

I UNDERSTAND THAT I MAY INCUR FEES FOR RECEIVING COPIES OF MY MEDICAL RECORDS. FEES FOR COPIES OF MEDICAL RECORDS ARE REGULATED BY THE STATE OF MICHIGAN.

Patient or Authorized Representative Signature

Date

Print Name

Relationship to Patient (if applicable)

(For Office Use Only)

Medical Record Number: _____

Date Processed: _____

ID Verified: ☐ Yes ☐ No