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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Prior Name _____ _____
Patient Telephone Number

Patient Address _____ _____
Street City/State/Zip Date of Birth

INFORMATION TO BE RELEASED: **Date of Service** _____

History/Physical Office Notes Laboratory Results Radiology Reports
Operations/Pathology Discharge Summary Psychological/Psychiatric Evaluation/Report
Urine/Serum Drug Screens Billing Pharmacy Entire Medical Records
Immunization/Vaccine Records Consultation Reports/Evaluations Other _____

RELEASE TO:

_____
_____
_____

RELEASE FROM:

_____
_____
_____

This release shall only apply to medical and billing records originally generated by the above provider. **Unless approximate dates are identified above, it will be assumed that the release will include specified items for only the most recent two-year period.**
This release of information consent form remains in effect for a maximum of 6 months or until date specified _____ (date).
I understand that I have the **right to revoke this authorization.** I may revoke this authorization by writing to Robert Levy MD, PC 2845 Monroe Dearborn, MI 48124.
I understand that information disclosed under **this Authorization could be redisclosed by the recipient and Robert Levy MD, PC is not responsible.** However, the recipient is held to all standards set in all aspects of Federal Regulations 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. The federal privacy rules may not protect my health information once the recipient rediscloses my health information.
A photocopy or fax of this authorization will be treated in the same manner as the original.
I understand that **I may decline to sign this authorization.** I understand the Robert Levy MD, PC may not refuse to treat me if I do not sign this authorization. However, **if the purpose of my treatment is solely to disclose health information to a third party,** the provider may refuse to treat me if I do not agree to authorize disclosure of my health information to that third party.
This release also authorizes verbal communication with law enforcement agencies.
No charge for medical records released directly to provider/facility for continued care.
There is a copying fee for medical records released directly to patient (s) for personal use or to others for non-patient care use.
Release of information Form must be filled out completely for request to be processed.

_____ _____ _____
Signature of Patient or Legal Guardian **Relationship** **Date**

_____
Witness / Date