Surgeons Choice Medical Center
Oakland Nursing Center
22401 Foster Winter Dr.
Southfield, MI 48075
Phone: 248-423-5171 Fax: 248-423-5177

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: _____

Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Phone: _____

Fax: (healthcare provider/facility only) _____

I authorize the following protected health information to be released from my medical record(s):
(PLEASE CHECK ALL THAT APPLY):

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

Please indicate the period of healthcare: Specific Date(s): _____ to _____
OR O **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***