

MICHIGAN CORNEA CONSULTANTS, P.C.

29201 Telegraph Rd., Suite 101, Southfield, MI 48034 Ph (248) 350-1130 Fax (248) 350-2709

Authorization for Release of Protected Health Information (PHI)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth: Month _____ Day _____ Year _____ Social Security # _____

Phone Number () _____ - _____ or () _____ - _____

Requesting:

- Medical Record to include: History and Physical Exam; Progress Notes; Laboratory Tests, Dictated Letters, billing information for the following date(s) of service _____.
(Only circled information will be copied)

The purpose of this release of information is for: (Please check one)

- Transfer of Records to another physician, attorney request or other (such as a insurance company) or records service. (Please circle)

I hereby authorize disclosure of my protected health information from __________ **to be sent to:**

Name _____ City _____

State _____ Zip Code _____ Phone #() _____ - _____ Fax #() _____ - _____

I understand the following HIPAA provisions:

I understand that my records are protected under HIPAA/PHI regulations.

I understand that under the Federal Protected Health Information regulations, I have the right to review my record and request amendments where appropriate.

I understand that my health information may be subject to re-disclosure and not protected by federal or state statutes (medical emergencies, reporting of communicable diseases as required under Public Health statues, subpoenas by government agencies upon appropriate and authorized court orders).

I understand that the specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

I understand that there is a fee permitted for copying medical records.

I understand that I may revoke this authorization at any time by notifying Michigan Cornea Consultants (MCC) in writing except that revocation will not cancel any action already taken by MCC upon the original Authorization for Release of PHI.

I understand that this Authorization of Release will expire in 90 days from the date signed.

Patient/Guardian Signature _____ Date _____

Print Name/Guardian _____ Phone # () _____ - _____
(if different from the patient phone # given above)