CLARKSTON MEDICAL GROUP, P.C.
5701 Bow Pointe Dr., Suite 100
Clarkston, MI 48346
Phone: 248-384-8132 Fax: 248-625-4996

ASSOCIATED RADIOLOGISTS OF CLARKSTON, PLC
5701 Bow Pointe Dr., Suite 110, Clarkston, MI 48346
7210 North Main Street, Suite 211, Clarkston, MI 48346

CLARKSTON URGENT CARE, PLC
5701 Bow Pointe Dr., Suite 120
Clarkston, MI 48346

Medical Records Release Authorization Form

***Form must be filled out completely in order to avoid any processing delays*.**

FEES FOR COPIES: Federal and State laws permit a fee to be charged for the copying and mailing of patient records. This facility has contracted with HealthPort (800-367-1500) to make copies. If a fee applies, you may be required to pre-pay for the copies or your copies will be mailed along with an invoice.

Authorization for Use and Disclosure of Health Information (Required by State and Federal Law)

I Hereby Authorize the Use and Disclosure of Health Information for the Following Patient:

Patient Name:_____ DOB: ___/____/_____
Last First Middle

Address: _____ Social Security: _____
Street Address City State Zip Code

Home Phone: _____ Business Phone: _____

Information About the Person or Organization Requesting the Release of Health Information, *if Other Than the Patient*:

Name: _____

Relationship to Patient: _____ ☐ Documents of Relationship to Patient Attached

Address: _____
Street Address City State Zip Code

Phone: _____ Fax Number: _____

Information About the Person or Organization Releasing Health Information:

Name: _____

Address: _____
Street Address City State Zip Code

Phone: _____ Fax Number: _____

Information About the Recipient of Health Information:

Name of Person or Organization Receiving Health Information: _____

Address: _____
Street Address City State Zip Code

Phone: _____ Fax Number: _____

This Authorization Applies To The Following Health Information (Check All Applicable):

☐ All Records of Clarkston Medical Group, P.C.
☐ All Records of Associated Radiologists of Clarkston, PLC
☐ All Records of Clarkston Urgent Care, PLC
☐ All Records pertaining to: _____
☐ Lab Results
☐ Radiology Reports for the date of service.
☐ Immunizations
☐ Other _____
☐ This Authorization applies only to the following dates of service: ____/____/____, ____/____/____, ____/_____/____.
☐ This Authorization applies only to the dates of service during the period of time: From: ____/____/____ To: ____/____/____.

A Specific Authorization Is Required To Release Information Regarding The Following:

	Yes	No	Initials
HIV Information or other communicable diseases	☐	☐	_____
Drug/Alcohol Information	☐	☐	_____
Mental Health Information	☐	☐	_____

This Authorization shall be valid until ___/____/____. If no date is given, this Authorization will be valid for 90 days only.

Patient's health information may be used and disclosed as described above until this Authorization expires. Patient or Patient's Authorized Representative may revoke this Authorization at any time by sending or delivering a signed revocation to the address listed at the bottom of the form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the Authorization was valid.

Patient's treatment may not be conditioned on whether the Patient of Patient's Authorized Representative signs this Authorization. The Patient or Patient's Authorized Representative will receive a copy of this signed Authorization upon request. Patient's health information released pursuant to this Authorization might be re-disclosed by the recipient, and any such re-disclosure may not be protected by law.

Patient Signature: _____ Date: ___/___/_____

Patient's Authorized Representatives Signature: _____ Date: ___/___/_____

Witness: _____ Date: ___/___/_____

For Office Use Only:

Fee Received $ _____ Processor's Initial's _____ Date Sent Out: ____/____/_____