



BARBARA ANN CENTER FOR FAMILY MEDICINE

15565 Northland Dr. Suite-108E

Southfield, MI 48075

Tel. 248-905-5470

Fax-248-905-5472

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Name Last	First	Middle	Date of Birth	Social Security Number
Address		City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from

Physician/Facility	Phone		
Address	City	Zip	Fax

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

Physician/Facility	Barbara Ann Center For Family Medicine	Phone	248-905-5470				
Address	15565 Northland Dr., Ste. 108E	City	Southfield, MI	Zip	48075	Fax	248-905-5472

RELEASE INFORMATION

Reason: Change of insurance Specialist Consultation Legal
 Transfer of Care Personal File Other

Please release the following (check all that apply)

ENTIRE MEDICAL RECORD	LAST THREE VISITS
LAB REPORTS	X-RAY REPORTS
HOSPITAL REPORTS	OTHER:

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test results.

I understand that I may be charged for copies provided. (See reverse side.)

YES NO Initials

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Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
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Witnessed by	Date
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Note: This consent is valid for 90 days. It may be revoked by the signer at any time.