Medical Records Department

26211 Central Park Blvd, Suite 201, Southfield, Michigan 48076
Phone 248-929-9365 - Fax 844-598-9633

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

INSTRUCTIONS: Fill in the appropriate information in **sections 1 through 5**. Sign and date the form.
A separate release must be completed for each request. Incomplete releases will be returned to you.

PROCESSING: Many requests for records are processed by our records management company, Chart Request.
Please be aware that, if applicable, Chart Request may contact you by phone or email in regards to processing your request.

1. Patient Full Name:____________________ **Date of Birth:**__________

Patient's Email:____________________

2. Information is to be released to:

Name:____________________ Attention:________________

Address: ______________________________

ID #______________ Phone:______________ Fax:______________

3. Reason for release of information:

- O Personal Records
- O Continuation of Care
- O Attorney
- O To have on file to release if requested
- O Insurance
- O Disability
- O Other ____________________

4. Specific information to be released (also indicate dates of service):

- O Office Notes________________
- O Form________________
- O Test Results________________
- O X-Ray Imaging CD ($10 per CD)________________
- O Imaging Report________________
- O Other:________________

5. Method of delivery:

- O Mail
- O Fax
- O Pick Up
- O Download Online at www.Chart Request.com
- O I hereby authorize verbal communication with the person or entity listed above.

- I hereby authorize **Michigan Orthopaedic Surgeons, PLLC,** or its record management company, ChartRequest, to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as specified below, to the person or entity listed on this form.
- I understand information released or disclosed may include information relating to alcohol, drug abuse, sexually transmitted diseases, AIDS and HIV.
- I may inspect the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the Michigan Orthopaedic Surgeons, to request a revocation of authorization form, but revoking this authorization will not affect disclosures made or actions taken before revocation is received.
- The person or entity to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information is no longer protected by HIPAA.
- I may refuse to sign this authorization and my provider will not condition treatment or payment based on me providing this authorization.
- This authorization will expire 1 year from the date of signature below, unless otherwise specified: ________________
- **Requests for records may be processed by the record management company ChartRequest who can be contacted by phone at 888-895-8366 or email at support@chartrequest.com.**
- I acknowledge the Michigan Orthopaedic Surgeons, PLLC, or its record management company, ChartRequest, reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature:____________________ **Date**:____________
Patient, parent of minor, legal guardian, personal representative, heir at law or person with authority

Print Name:________________ **Relationship** (if other than patient):____________

If legal guardian, personal representative, heir to law or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release.