Paul Benson, D.O., P.C. - Be Well Medical Center, *a Division of MHP*
1964 Eleven Mile Road | Berkley, MI 48072 | Ph: (248) 544-9300 | Fax: (248)544-1148

AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Instructions: Fill in the appropriate information in each applicable section. Sign and date the form. Incomplete forms will not be processed. You must complete a separate authorization for each request.

This authorization is voluntary. Your care or treatment will not be conditioned on signing this authorization.

***STEP 1*: Patient Information:**

Name: _____ Maiden Name: _____ Sex: M / F Nickname: _____

Date of Birth: _____ Phone No: _____ E-mail: _____

Street Address: _____ City/State/Zip: _____

***STEP 2*:** I, _____ [PRINT YOUR NAME], **HEREBY AUTHORIZE**

☐ Paul Benson, D.O., P.C. - Be Well Medical Center, 1964 Eleven Mile Road, Berkley, MI 48072

OR

☐ Other: _____ Address: _____
Name of person/organization releasing information _____

Its Director, designee, agent, or medical records department, **TO RELEASE INFORMATION** contained in my patient record, which includes information that may be stored in paper or electronic form. I understand that my record may contain information on my care plan; medications; birth control and abortion (family planning); genetic diseases or test results; information relating to sexually transmitted diseases or infections, hepatitis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and any other communicable diseases; and information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

***STEP 3*: TO:**

☐ Paul Benson, D.O., P.C. - Be Well Medical Center, 1964 Eleven Mile Road, Berkley, MI 48072

OR

☐ Other: Individual: _____ Organization: _____
Address: _____ Telephone No: _____
_____

***STEP 4*: Information to be**: ☐ Faxed (Doctor's Office & Hospitals only) – Fax No.: _____
☐ Picked up by: ☐ Patient ☐ Other – Name: _____

(If someone other than the patient is picking up records, must provide a letter of authorization signed by patient or authorized representative.)

***STEP 5*: Purpose or need for disclosure** (if requested by person other than patient or authorized representative):

☐ At the request of patient ☐ Continuation of Treatment or Care ☐ Insurance ☐ Disability Determination
☐ Attorney/Legal ☐ Workman's Compensation ☐ Other: _____

***STEP 6*: Specify type of information to be disclosed** and date**: *Date From*: _____ *To*: _____

☐ Immunization ☐ Billing Information ☐ Labs ☐ Radiology/X-Ray ☐ Discharge Summary
☐ ER Reports ☐ All clinical written documentation ☐ Other: _____

***STEP 7*: Revoking authorization**: This authorization is subject to written revocation at any time except to the extent that the organization identified in Step 2 has already taken action in reliance on the authorization.

***STEP 8*: This authorization will expire upon disclosure of requested information or** _____ (*if left blank, the authorization expires 60 days from the signature date*).

** ***STEP 9*: Payment**: There may be fees associated with the records request. Please contact the organization in Step 2 for details.

***STEP 10*: Note**: Once information has been disclosed, the organization can no longer protect it from further disclosure.

_____ _____ _____
Signature of Patient / Legally Authorized Representative Printed Name Date

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Next-of-Kin ☐ Legal Guardian ☐ Power of Attorney