Michigan Orthopaedic Institute
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☐ FORM ATTACHED

PATIENT INFORMATION RELEASE AUTHORIZATION

INSTRUCTIONS

Fill in the appropriate information in each applicable section. Sign and date the form. **Incomplete forms** will be returned to you unprocessed. A **separate** authorization must be completed for each request.

Patient Full Name: ____
Last | First | Initial

Date of Birth: _______________ Last 4 Digits of SS# ______ Sex: M / F Telephone: (_____) _______________

Address: Street: ____
City: ________________________________ State: _______________ Zip: ____________

I, ____________________________ hereby authorize **MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.,** it's director or agent, 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 set forth below. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care providers. **Not for use for disclosure of psychotherapy notes.*

1. Name or title of person or organization and address to whom information is to be:

Disclosed To: ____
____
____
____
Address

How do you want to receive your request?
*****Please check appropriate box below*****

☐ Mail to ______________________
☐ Fax to ______________________
☐ Call to Pick Up ______________

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2. The purpose or need for such disclosure

____At the request of the patient ____Personal Use ____Continuation of Care _____Attorney
____Workman's Compensation ____Insurance ____Disability ____Other:________________

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3. Specific information to be disclosed/obtained as related to #2. **Indicate date of service:**

___Office Notes ______________________________ ___Operative Report ______________________________
___Test Results______________________________ ___X-Ray Disc______________________________
___Other (specify) ____

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4. This authorization is valid only if received by Michigan Orthopaedic Institute, P.C. within 60 days of the date signed.

5. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _______________ (date cannot exceed one year from the date of signature below).

6. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization. Contact Michigan Orthopaedic Institute, P.C., 26025 Lahser Road, 2nd Floor, Southfield, Michigan 48033

7. My care or treatment will not be conditioned on signing this authorization.

8. The persons 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 may no longer be protected by law.

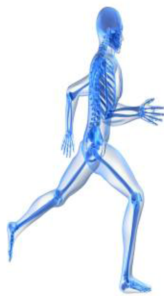
9. Michigan Orthopaedic Institute, P.C. reserves the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature: ________________________________ Relationship (if other than patient): ________________________
Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

Date: ________________________

* If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release

For office use only received by: ______________________



Frequently Asked Questions – Medical Records

Incomplete forms will be returned to you unprocessed.
A separate authorization must be completed for each request.

PLEASE ALLOW 10 – 15 BUSINESS DAYS FOR PROCESSING

How do I request my Medical Records?
Print and complete the Patient Information Release Authorization. This form **must** be signed and dated.

Who may sign the Patient Information Release Authorization?
Only the patient, the patient's legal guardian, the parent of a minor patient or the personal representative of a deceased patient may sign. If the patient is not signing, a copy of the Letters of Authority as Legal Guardian, Medical Power of Attorney, or Personal Representative must accompany the form. The form **must** be completed in full (with the exception of #5-which is only for ongoing access in treatment settings). Incomplete forms will be returned.

How do I obtain my records?
Option #1 - Request by mail
Option #2 - Pick up/Walk in (advance notice required)
Option #3 - Pick up: by a person other than the patient

How do I complete item #1 on the Authorization form (Name or title of person or organization and address to whom information is to be)?
Disclosed To: If you wish the record to go to yourself - put your name as the person to release the records to. If you wish someone else to be sent (or pick up) the records put their name (and address for those requiring mailing).

What identification is required?
Requested by mail: Signature and address will be compared. Copy of drivers' license may be requested.

Pick Up/Walk In: Drivers' license or valid picture ID will be required.

Mail completed forms to:

Michigan Orthopaedic Institute, P.C.
Attn: Medical Records
26025 Lasher Road
2nd Floor
Southfield, MI 48033

OR

Fax to: 248-663-1924