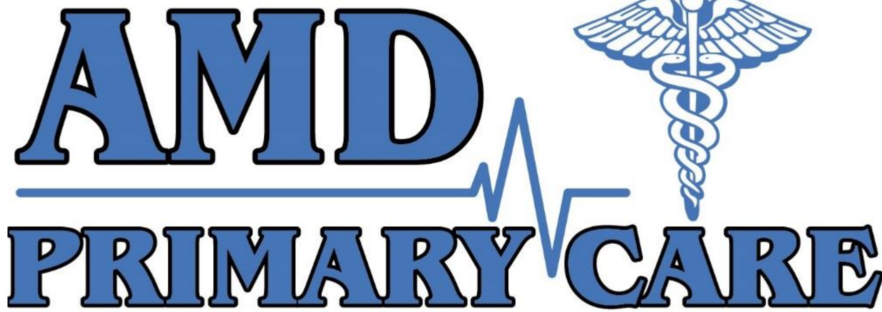

7070 Miller Rd. Suite A
Swartz Creek, MI 48473
Office: 810.564.7995, Opt. 4
Fax: 810.221.1340
Email: amdurgentcare@gmail.com
Website: www.amdurgentcare.com

RELEASE OF MEDICAL INFORMATION/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S INFORMATION

Patient Name (Print):____________________________________ Date of Birth: _____/______/______

Address: ___________________________ Phone: _________________________

____

____

INFORMATION TO BE USED OR DISCLOSED

☐ Release ALL of my protected health information including any substance abuse treatment, mental health treatment, HIV-AIDS related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, laboratory test results, X-rays, X-Ray over reads, MRI results, CT results and any other information in the records.

AUTHORIZATION FOR RELEASE

I, _______________________________, HEREBY AUTHORIZE _____________________________ TO RELEASE, DISCLOSE, AND DELIVER THE MEDICAL INFORMATION DESCRIBED ABOVE.

I HEREBY REQUEST THAT THE ABOVE REQUESTED INFORMATION BE SENT TO

AMD PRIMARY CARE

7070 MILLER RD, SUITE A

SWARTZ CREEK, MI 48473

Phone: 810-564-7995

Fax: 810-462-1191

REDISCLOSURE

This release does not authorize the redisclosure of medical information. The recipients of this information are prohibited from using the information for anything other than the purpose stated here and from disclosing it to another party without further authorization.

SIGNATURE OF PATIENT____ DATE______________________

SIGNATURE OF REPRESENTATIVE (IF APPLICABLE)____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT____