Orion Family Physicians
1455 S. Lapeer Road, Suite 100
Lake Orion, Michigan 48360
Office: 248-693-3551 Fax: 248-693-4643

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, authorize Dr. _____.
Phone #_____, and its physicians, agents, and employees to provide for a photocopy or allow for medical records specified below
regarding _____to be inspected or reviewed for the express purpose of management and coordination of clinical services and care.

I authorize the release of the medical information specified below regarding the above named patient:
To_____
NAME

_____
ADDRESS CITY STATE ZIP PHONE

For the purpose indicated above. The following information is subject of this information.

__ The entire medical record and history of care.
__ Portions of the medical record for the period _____ to _____, including
- __Any diagnostic information (diagnosis, lab, and tests and results)
- __ Specific diagnosis:_____
- __ Office and progress notes for the period indicated
- __ Hospital admissions and discharge summaries
- __ Hospital notes
- __ Operative reports, notes, findings

I understand and agree that the patient records may include:
* Alcohol and drug abuse information protected under the regulation in 42 Code Of Federal Regulations, Part 2 if any; and
* Psychological and or social service information, if any; and
* Information about HIV, Aids, and ARC, protected under MCL333.5131 or any communicable disease.

This authorization is valid for a maximum of (2) two years from the date of signature below or until expressly revoked by the undersigned.

_____ _____
Signature of Patient or Patient's Legal Representative Date

Patient Date of Birth:_____
Patient's Maiden Name: _____
Patient's Address: _____
_____

****You will be billed directly from Health Port for this service.**

_____ _____
Witness Date