

# AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

## I Hereby Authorize the Disclosure of my Health Information From:

JOSEPH Advanced Facial Plastic Surgery, PLLC

Name of Person/Organization Releasing Information

3940 John R Road

Address

Troy, MI 48083

City / State / Zip

Ph: 947-217-3223; Fax: (248) 817-3994

Phone Number // Fax Number

## To Release my Information To:

\_\_\_\_\_  
Name of Person/Organization Receiving Information

\_\_\_\_\_  
Address

\_\_\_\_\_  
City / State / Zip

\_\_\_\_\_  
Phone Number // Fax Number

## INFORMATION TO BE RELEASED:

\_\_\_\_\_ Complete Medical Record

\_\_\_\_\_ Medical Records for Specific Dates of Service (please list) from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Other (please list) \_\_\_\_\_

**This authorization remain in effect until the information has been forwarded as requested.**

## RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X \_\_\_\_\_

Printed Name of Patient or Personal Representative

X \_\_\_\_\_

Signature of Patient or Personal Representative

DATE

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: \_\_\_\_\_ By: \_\_\_\_\_ Via: \_\_\_\_\_