

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:

Name of Person/Organization Releasing Information

Address City / State / Zip

Phone Number // Fax Number

To Release my Information To:

JOSEPH Advanced Oculofacial Plastic Surgery

Name of Person/Organization Receiving Information

3435 Livernois Rd Troy, MI 48083
Address City / State / Zip

Phone: 947-217-3223; (248) 817-3994

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)

Date Sent: _____ By: _____ Via: _____