Trenton Total Health Care Center
A patient-centric Care Provider

MEDICAL INFORMATION RELEASE

MEDICAL INFORMATION RELEASE AUTHORIZATION

PATIENT INFORMATION	
Patient Full Name	
Date of Birth	
Phone #	
Address	

ORGANIZATION INFORMATION	
Release Medical Information ☐ **From** or ☐ **To** (Please check only one)	
Name of the Organization	
Name of the Person	
Address	
Phone #	
Fax #	

TYPE OF MEDICAL INFORMATION TO BE RELEASED

- ☐ Entire Medical Record
- ☐ X-Ray
- ☐ Lab Reports
- ☐ Immunization
- ☐ Hospital Reports
- ☐ Hospital Discharge Summary
- ☐ Other (please specify) _____

PURPOSE OF RELEASE

- ☐ Specialist
- ☐ Second Opinion
- ☐ Legal
- ☐ FMLA
- ☐ Disability
- ☐ Workers Comp
- ☐ Insurance
- ☐ School
- ☐ Continuation of Care
- ☐ Other, please specify _____

AUTHORIZATION

By signing this form, I am attesting to the fact that the records I am requesting be released, and may include alcohol, substance abuse, mental health status, and serious infectious and communicable diseases (including venereal diseases, tuberculosis, Hepatitis C, and HIV infection) are protected under State of Michigan and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that I may revoke this authorization in writing at any time and that this authorization pertains to fulfillment of the above stated request. This release expires one year from the date of signature. I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Trenton Total Health Care Center, PC and or its copying services reserve the right to charge for processing and copy information. This fee is waived when releasing information directly to a treating physician or a health care facility

X_____ **SIGNATURE**	_____ **RELATIONSHIP TO THE PATIENT**	_____ **DATE**
X_____ **WITNESS SIGNATURE**		_____ **DATE**

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