Flat Rock Physicians

Colleen Browne, D.O. or David Patterson, D.O.

25620 Gibraltar Rd.

Flat Rock, MI 48134

Telephone (734)789-9355

Fax for Dr. Browne (833)673-0305 Fax for Dr. Patterson (734)789-9365

Request for Medical Records Release

Date_____ Patient Name_____

Date of Birth_____ SSN____-__-____

Here by authorize Name _____ (doctor releasing the records),

Address:

Phone number_____ Fax number_____

It's director or agent to release information contained in the medical record of the patient identified above, which includes information that maybe stored in a paper and/or electric format. This includes information concerning human immunodeficiency (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC), if any, protected under the Michigan Public Act 174 of 2989, as amended, and substance abuse information, if any, protected under 42 Code of Federal Regulations. Part 2; and social and psychological services information, if any, including communications made to a social worker or psychologist, if any to the individuals or organizations and only under the conditions listed below:

Colleen Browne, D.O. or David Patterson, D.O.

25620 Gibraltar Rd.

Flat Rock, MI 48134

Fax for Dr. Browne (833)673-0305 Fax for Dr. Patterson (734)789-9365

1. **The purpose or need for such disclosure?**
   ____ Personal use ___ Continuation of Care ___Attorney ___ Workmen's Comp ___ Insurance ___ Disability ___Other
2. **Specific information to be disclosed /obtained as related to (date of service)**
   ___ ER Memo ___ Outpatient visit ___ X-Ray ___Discharge summary ___ Immunization ___ Entire Record
3. **This authorization is valid only if received by the above listed physician within 90 days of the date signed. I may revoke the authorization anytime. Revocations will not apply to the information that had already been released pursuant to this authorization.**
4. **Information used/disclosed pursuant to the authorization may be subject to redisclosure by the recipient and will no longer be proceeded by the rule.**
5. **The above mentioned physician reserve the right to charge for processing and coping information. The fee waived releasing information directly to a treating physician or health care facility.**

I hereby, authorized the release of all necessary medical records to Flat Rock Physicians. I wish them forwarded as soon as possible.

Patient Signature_____Date_____
(If other than Patient)

Patient Address_____City_____

State_____Zip Code_____

Signature of Witness_____Date_____
(If legal guardian or Personal Representative, a copy of appropriate documentation is required