

**REQUEST OF RECORDS FROM
FAMILY PRACTICE CENTRE OF LIVONIA and CANTON, P.C.**

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

D.O.B.: _____ SOC. SEC. #: _____

By signing below, I hereby authorize:

Family Practice Centre of Livonia, P.C.
38253 Ann Arbor Road
Livonia, MI 48150
Attn: Privacy Officer

Family Practice Centre of Canton
8532 N. Canton Center Rd.
Canton, MI 48187
Attn: Privacy Officer

to use or disclose the following protected health information. (*Specifically describe the information to be disclosed including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.*)

I hereby authorize Family Practice Centre of Livonia, P.C. to disclose my protected health information to the following:
Please include the complete address and phone number to ensure a timely delivery of records.

The Protected Health Information is being used or disclosed for the following purposes: _____

This Authorization is in effect from the date signed below until: _____
Expiration date or event

I understand that I have the right to revoke this authorization, in writing, at any time by sending notification to the Family Practice Centre office listed above.

I understand that a revocation is not effective to the extent that Family Practice Centre of Livonia, P.C. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or request a copy of my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

I understand that I may be charged for copies provided. Yes _____ No _____ Initials _____

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Representative's Authority