REQUEST OF RECORDS

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

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

PROVIDER OR FACILITY NAME, ADDRESS AND PHONE NUMBER:
(referred to in this document as "the provider")

_____

_____

_____

By signing below, I herby authorize the provider 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 the provider to disclose my protected health information to the following:

❑ Family Practice Centre of Livonia, P.C.
38253 Ann Arbor Road
Livonia, MI 48150
Attn: Medical Records

❑ Family Practice Centre of Canton
8532 N Canton Center Rd
Canton, MI 48187
Attn: Medical 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 provider I have requested the information from.

I understand that a revocation is not effective to the extent that the provider 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