Authorization To Release Information

Patient Name ______________________ Birthdate ____________ Medical Record Number ______________________

Address ____

Phone Number ______________________ Maiden/Other Names ______________________

I Authorize

Name ______________________

Address ______________________

City, State, ZIP ______________________

Telephone/Fax ______________________

To Release To

Ausi Medical Center
5032 Rochester Rd., Suite 200
Troy, MI 48085
P: 248-250-6373
F: 248-250-6370

Specific Type of Information To Be Disclosed:

Date(s) of Service ______________________

- ☐ History and Physical
- ☐ Operative Report
- ☐ Physician's Notes
- ☐ Consultation Reports
- ☐ Therapy Notes
- ☐ Discharge Summary
- ☐ Laboratory Results
- ☐ Billing Notes
- ☐ Home Care Records
- ☐ Diagnostic Imaging (e.g. X-Rays) reports from (date) ______________
- ☐ Diagnostic Imaging (e.g. X-Rays) films from (date) ______________
- ☐ Other ____

Sensitive Information To Be Disclosed:

Date(s) of Service ______________________

- ☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
- ☐ Referrals and Treatment for Alcohol and Substance Use Disorder
- ☐ Communicable Diseases Such As Sexually Transmitted Diseases and Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent To Release Entire Medical Record, For Dates of Service Listed, Including All Information Noted Above:**

Date(s) of Service ______________________ Initials ______________ Date ______________

Please Continue To The Otherside Of This Form for Acknowledgments and Signatures.

By signing this form I understand:

1. That I do not need to sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.
2. My health information may be shared electronically.
3. The sharing of my health information will follow state and federal law regulations.
4. This form does not give my consent to share psychotherapy notes as defined by federal law.
5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.
6. I should tell all agencies and people listed on this form when I withdraw my consent.
7. I can have a copy of this form.
8. That otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol, or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV).
9. That any disclosure or information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.
10. I understand that if I request Ausi Medical to email me a copy of my medical record, it may not be possible due to mailbox size and/or security restrictions. I also understand that if Ausi Medical is able to send my record to my email, Ausi Medical will apply reasonable safeguards but cannot guarantee the security of your record when sending it to an unsecured personal email account.
11. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

______________________________ ______________

Signature of Patient or Legal Representative **Date**

____

If Signed by Legal Representative, State Relationship to Patient

______________________________ ______________

Signature of Witness **Date**