

Professional Village Medical Center
13700 19 Mile Road
Sterling Heights, MI 48313
P: (586) 247-6020
F: (586) 737-2338
F: (586) 247-7048

Records Release Authorization

Patient Name: _____ Date: _____

Date of Birth: _____ Phone Number: _____

Please Release Records From: _____
(Office/ Doctor Name)

(Address)

(Phone Number) (Fax Number)

I hereby request that you release information contained in my medical record, which includes information that may be stored in a paper and/or electronic format, as set forth below:

X-Ray: _____ CT: _____ MRI: _____ Ultrasound: _____

Labs: _____

Consultation Note: _____ Hospital Notes: _____ Discharge Summary: _____

Cardiac Testing: _____ Immunization: _____ All Records: _____

Other (specify): _____

Please send records to:
Professional Village Medical Center
Dr. John S. DeMare
Dr. Steven Shepherd
Dr. Joyce McDonald
Dr. Frank DiPonio
13700 19 Mile Road, Sterling Heights, MI 48313
F: (586) 737-2338 F: (586) 247-7048

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to our offices. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

(Patient or Guardian Signature)

(Date)