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: _____

Consult/Office 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)**