MyCare Health Center

18 Market Street, Suite C, Mt. Clemens, MI 48043 P: 586.783.2222 F: 586.783.6280
6900 E. Ten Mile Road, Center Line, MI 48015 P: 586.756.7777 F: 586.756.7788
43740 Groesbeck Highway, Clinton Township, MI 48036 P: 586.493.0961 F: 586.493.1001

www.mycarehealthcenter.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
(First) (Middle) (Last) (Previous Name)

Address: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Social Security Number_____ My Provider at **MyCare** is: _____

Release Records from **MyCare Health Center To:**	Release Records To **MyCare Health Center From**:
_____ (Name) _____ (Address) _____ (City) (State) (ZIP) _____ (Phone) (FAX)	**Mt. Clemens Centerline Garfield Groesbeck** _____ (Name) _____ (Address) _____ (City) (State) (ZIP) _____ (Phone) (FAX)

Reason for record request: _____

IMPORTANT - You may disclose health care information regarding testing, diagnosis, and treatment for (check yes or no):	**Information to be released (be specific):**
( ) Yes ( ) No HIV (AIDS virus) ( ) Yes ( ) No Sexually transmitted diseases ( ) Yes ( ) No Psychiatric disorders/mental health ( ) Yes ( ) No Drug and/or alcohol use	□ Last 2 years of records □ Last 5 years of records □ X-ray (specify dates) _____ □ Only dates of service from _____ to _____ □ Other records (specify)_____

This authorization expires within one calendar year of being signed. If you wish to have the authorization expire before one calendar year please indicate the date of expiration: _____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing by sending such written revocation to MyCare Health Center at the above address. If I did, it would not affect any actions already taken by MyCare Health Center based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may inspect or copy (at additional expense) the information to be used or disclosed, as provided in CFR 164.524. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent or legal representative)