MICHIGAN EYE INSTITUTE

Name: ____________________
Birthdate: ________ **Cell Phone:** ________ **Home Phone:** ________
Address: ________ **City/State/Zip:** ________
Email: ____________________

1.) I hereby authorize records FROM:
Name: ____________________
Address: ____________________
Phone: ________ Fax: ________

2.) To be released TO:
Name: ____________________
Address: ____________________
Phone: ________ Fax: ________

3.) Purpose of Disclosure: ____________________

4.) Records Format:	**5.) Specific Information to be released:**
☐ Paper Copies via postal mail	☐ All Records
☐ Electronic Access via Email	☐ Date Range: ________
☐ Fax (If under 20 pages)	☐ Other: ________
☐ Pick Up	

I understand authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I understand treatment will not be conditioned on my signing this authorization. I understand that any disclosure of my information carries with it the potential for an authorized re-disclosure and the information may no longer be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 6 months from the date signed.
I have read the information provided on this release form and do hereby acknowledge that I fully understand the terms and conditions of this authorization.

____________________ ________

6.) Signature of Patient/Guardian/Authorized Representative **Date**

*We reserve the right to charge the fee schedule as set by the State of Michigan Records Access Act.

Revised 7/2018