DMC
DETROIT MEDICAL CENTER

☐ CHM ☐ KEI
☐ DRH ☐ RIM
☐ HUH ☐ SGH
☐ HVSH ☐ HEART
☐ HWH ☐ _____

321

Patient Label

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(NOT FOR PSYCHOTHERAPY NOTES)

Patient Name _____ Maiden / Other Name _____

Date of Birth ___/___/_____ Phone Number _____

Patient Address _____
Street City State Zip

I authorize _____
Healthcare facility / physician
to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services)

Name to whom information may be released: CD Services INC

24027 Research Drive	Farmington Hills	MI	48335
Address	City	State	Zip Code

248-476-1700	248-476-6600
Area Code Telephone Number	Fax Number

Date(s) of Treatment: _____

Specific Type of Information to be Disclosed

☐ Discharge Summary
☐ History & Physical
☐ Consultations
☐ Laboratory Results
☐ X-Ray Reports
☒ X-Ray Images / CD
☐ Operative Reports
☐ Pathology Reports
☐ ED Reports
☒ Other(specify): Entire Medical Record DOB to Present Including Billing
☐ Clinic / Doctor's Office(specify): _____

Method of Disclosure

☐ Paper
☒ Electronic, where available
☐ Other(specify): _____

The Purpose and Need for Such Disclosure: All purposes allowable by law

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. 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.

_____ ___/___/_____
Signature of Patient / Parent / Personal Representative Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

_____ _____
Relationship to Patient Print Name

Source of Authority _____