NOVI docs
CARING FOR ALL GENERATIONS
Novi Internal Medicine and Pediatrics
A Division of Envision Medical Group, PLLC

NOVI INTERNAL MEDICINE AND PEDIATRICS

A Division of Envision Medical Group, PLLC

Authorization for Release of Medical Information

(There may be a charge for copying records.)

39475 Lewis Dr., Ste. 130
Novi, MI 48377
Phone: (248) 374-0502
Fax: (248) 374-0567

Patient Name_____ **Date of Birth:**_____

Previous Name:_____ **Phone Number:**_____

Address:_____ **City/State/Zip:**_____

It's Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records, protected under the regulations in 42 Code of Federal Regulations, Part 2, if any psychiatric/psychological services records, if any, and social work records, if any, including communicable diseases and serious communicable disease and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or organizations listed below, only under the conditions listed: _____

_____

1.

☐ REQUESTING Records From:	☐ RELEASING Records To:
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State : _____ Zip: _____	State : _____ Zip: _____

2. Specific type of information to be disclosed:
   ☐ All ☐ Discharge Summary ☐ Copy of Current Admission ☐ Immunizations & Patient Medical Records
   ☐ Specific Testing ☐ Other _____

3. The purpose and need for such disclosure:
   ☐ Moving ☐ Change of Insurance ☐ Changing Physician ☐ Continuation of Treatment or Health Care
   ☐ Follow-Up ☐ Dissatisfied with Office ☐ Social Service Referral ☐ Vocation Rehabilitation
   ☐ Billing Information ☐ Insurance Investigation ☐ Disability Determination
   ☐ Other (specify) _____
   ☐ Comments _____

4. Information to be: ☐ Mailed ☐ Picked Up If pick-up is checked, by whom(name, printed) _____

Include letter of authorization if someone other than patient. This authorization is subject to written revocation at any time except to the extent that Novi Internal Medicine and Pediatrics, A Division of Envision Medical Group, PLLC and _____ have already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate twelve (12) months from date of signature.

_____ _____ _____
Signature | Relationship to Patient | Date

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Novi Internal Medicine and Pediatrics, A Division of Envision Medical Group, PLLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

☐ I understand that Federal and state laws permit a fee to be charged for copying of patient records. This facility has contracted with HEALTHPORT to make copies. Your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING - note that the signature is required in two places.*

Signature of Individual*	Date of Individuals Signature	Date of Birth and Last 4 Digits of SS#
Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's / Personal Representative's Signature	Description of Authority to Act for the Individual