Medical Records Release Form

By signing this form, I authorize _____,

To release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/person/facility/ entity listed above.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed form is as follows:

O Complete Records	O History & Physical	O Progress Notes
O Care Plan	O Lab Reports	O Radiology Reports
O Pathology Reports	O Treatment Record	O Operative Reports
O Hospital Reports	O Medication Record	O Other (Please Specify)

Release my protected health information to the following:

Rochester Family Medicine PC
1308 W. Auburn Road
Rochester Hills, MI 48309
Phone: (248) 266-9504
Fax: (888) 977-1745

The purpose/reason for this release of information is as follows:

_____

_____

_____ _____
Patient Name Patient Signature or Personal Representative

_____ _____
Patient Date of Birth Date

_____ _____
Physicians Signature Date