David A. Detrisac, M.D.
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Bone Density Center

Authorization to Release Information

Print Patient's Name ______ Birth Date ______ Telephone Number ______

Address ______

I authorize ______ (name) ______ (address) ______ (city, state, zip) ______ (telephone/fax)

to release to ______ (name) ______ (address) ______ (city, state, zip) ______ (telephone/fax)

Specific type of information to be disclosed: Date(s) of Service: ______ to ______

- ☐ Progress Notes
- ☐ Surgical Reports
- ☐ Treatment/Care Information
- ☐ Test Reports
- ☐ X-ray Reports
- ☐ All Medical Records
- ☐ Work Status Reports
- ☐ Physical Therapy Reports
- ☐ Other: ______

The purpose and need for disclosure:

- ☐ Continuation of Care
- ☐ Personal
- ☐ Insurance Billing
- ☐ Legal/Attorney
- ☐ Prefer not to answer
- ☐ Other: ______

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA/Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than one (1) year after the date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

______ Signature of Patient or Legal Representative

______ Today's Date

______ If Signed by Legal Representative, State Relationship to Patient

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