

**RIVERBEND Health Care, P.C.**

44344 Dequindre Ste 480  
Sterling Heights MI 48314  
(586) 323-8935  
(586) 323-9058 fax

**PATIENT AUTHORIZATION FOR RELEASE OF RECORDS**

**PATIENT NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**Purpose of Request: I request and authorize the disclosure or release of my protected health information as identified below:**

**From:** \_\_\_\_\_  
(Name of Provider)

**To: Sharon K. Geimer, M.D.  
Riverbend Health Care, P.C.  
44344 Dequindre, Ste 480  
Sterling Heights, MI 48314**

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city/state/zip)

\_\_\_\_\_  
(Phone/Fax)

I authorize the disclosure of complete medical records, including information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS.

**Purpose of Disclosure:** \_\_\_ Change of Physician  
\_\_\_ Change of Insurance  
\_\_\_ Moving/New Address  
\_\_\_ Other

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**Expirations or termination of authorization** – This authorization is effective for 6 months from the date of execution, however, I may revoke it at any time by providing notice in writing to the above named party.

By signing the authorization, I acknowledge that I have read this form, I have had the opportunity to ask questions and that I comprehend this authorization.

**All requests remain valid for 6 months from the date of request**

\_\_\_\_\_  
(Signature of patient/or legal guardian)

\_\_\_\_\_  
(Date)

**Revocation Section:**

**I revoke this authorization:**

\_\_\_\_\_  
(Signature of patient/or legal guardian)

\_\_\_\_\_  
(Date)