RIVERBEND Health Care, P.C.
44344 Dequindre Ste 480
Sterling Heights MI 48314
(586) 323-8935
(586) 323-9058 fax

PATIENT AUTHROIZATION 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: Riverbend Health Care, P.C.
44344 Dequindre Ste 480
Sterling Heights, MI 48316

TO: _____
(Name of Provider/Physician)
_____
(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

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 authorization, 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)