APM&R
BRAIN • PAIN • SPORTS • SPINE

5333 McAuley Drive
Suite 2009
Ypsilanti MI, 48197

www.APMandR.com

p. 734.712.0050
f. 734.712.0055

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name_____

Date of Birth ____ /____ /_____ Social Security Number _ _ _ - _ _ - _ _ _ _

Information to be released from:

Name _____ City _____

Address_____ State_____ Zip_____

Phone (_ _ _) _ _ _ - _ _ _ _ Fax (_ _ _) _ _ _ - _ _ _ _

Information to be released to:

Name _____ City _____

Address_____ State_____ Zip_____

Phone (_ _ _) _ _ _ - _ _ _ _ Fax (_ _ _) _ _ _ - _ _ _ _

Specific information to be disclosed (include dates of treatment):

_____

Purpose or need for such disclosure:

_____

This information shall be in force or effect until this date: _____ /_____ /_____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Associates in Physical Medicine & Rehabilitation, P.C. 5333 McAuley Drive, Suite 2009, Ypsilanti, MI 48197, Attention: Privacy Officer.

This authorization will automatically expire six months from date of signature.

I understand that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the federal Privacy Standards.

I have read the above and acknowledge that I fully understand the terms and conditions of this authorization.

Patient's Signature: _____ Date: ____ /____ /____

If the patient is unable to sign or is a minor, complete the following:

Signature: _____ Date: ____ /____ /____

Relationship to patient:_____

Reason patient is unable to sign: _____

Witness:_____ Date: ____ /____ /____

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Tips for Record Requests

1. Provide as much information as you can on the authorization form. If your records are to be sent to another medical provider, please include name, address and, most importantly, fax number. Providing this information will expedite your request.

2. If you have a common name make sure you include your date of birth and the last 4 numbers of your social security number.

3. Bring a valid government-issued photo ID when you pick up a record request. The medical records professionals by law must deny requests where the individual cannot prove his or her identity or his or her right to access the records.

4. Be specific about information you want disclosed and the purpose for such disclosure.

5. Allow as much time as possible. Make your request well before you need the documents (between 10-15 days out).

6. If you are requesting another person's records, confirm in advance that you have authorization.

7. A completed and signed authorization form is mandatory for all record releases. An incomplete or unsigned request will not be fulfilled.

8. If you have any questions, call the APM&R Medical Records Department at 734-712-0050, option 5.

Doctor practice's have the right to charge fees to offset the labor involved in copying and assembling records. APM&R will waive the fee if the information is being sent to another provider for use in care. However, APM&R will charge a fee if the patient requests a personal copy of the record. The standard rate is:

First 20 pages: $1.14 per page
Per pg from page 21-50: $0.57 per page
Per pg from page 51+: $0.23 per page