KOUBA DERMATOLOGY

Authorization For Use or Disclosure of Medical Records Information

7301 Secor Road
Lambertville, MI 48144

Patient Information:

Patient Name:_____ Date of Birth:_____
Last 4 Numbers of Social Security #:_____ Maiden/Other Name:_____
Patient Address:_____
City:_____ State:____ Zip:_____ Preferred Phone Number:_____

Release Information From:

I hereby Authorize the below physician/facility to release my medical records information:
Name/Facility:_____ Attention:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____ Fax:_____

Release Information To::

I hereby Authorize the below physician/facility to release my medical records information:
Name/Facility:_____ Attention:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____ Fax:_____
Patient Email Address- Required if patient wants records emailed to self:_____
Specific dates of service to be released:_____
Records to be released: (check options(s) below)

- ☐ Physician Office Pertinent Transfer Package (standard two years of information)
- ☐ Progress Notes ☐ Laboratory/Path Reports ☐ Radiology Reports ☐ Radiology Reports & Disk ☐ Immunization Record
- ☐ Other - please be specific, include dates or testing needed:_____

**Note you could be invoiced at the allowable MI or OH Stature rate*

- ☐ **I DO** ☐ **I DO NOT** want information about **Behavior or Mental Health Services** released **I** *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **I DO NOT** want information about **Developmental Disability** released *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **I DO NOT** want information about **Genetic Testing** released *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **I DO NOT** want information about **Rape/Sexual Abuse** released *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **I DO NOT** want information about **Sexually Transmitted Disease (STDs)** released **I** *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **DO NOT** want information about **Social Worker Communication** released *Please initial to confirm your choice* _____
- ☐ **I DO** ☐ **IDO NOT** want information about **Substance Use Disorder** released *Please initial to confirm your choice* _____

STOP **Please confirm you have checked & initialed for each of the above, whether or not it is applicable to you. If the form is incomplete, we will be unable to process this request.**

This consent is valid for 1 year from the date of signature unless revoked by me in writing before release of information as designed above. A copy of this authorization, including the following disclosure statement, will be furnished to whom the information is to be released. This information has been disclosed to you from confidential records from disclosure by state law. You shall make no further disclosure of this information without specific written and informed release of the individual to whom it pertains, or as otherwise permitted by state law.

_____ _____
Signature of Patient **Date**

_____ _____
Parent/LegallyRecognizedRepresentativeSignature** **Date**

**If you are the legally recognized representative of the patient, you must provide supporting documentation.