



MI EXPRESS CARE
REDEFINING CARE & CONVENIENCE

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name (PRINT) _____ Guardian or Authorized Party (if applicable) _____ Date of Birth _____

I authorize the release and disclosure of my health information as described below:

Information requested:

- Records related to treatment dates from _____ to _____
- Records for all care at this facility or by this doctor
- Other (please specify) _____

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. To revoke this authorization, I must do so in writing. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the Federal Privacy Standards nor is this the responsibility of MI Express Care or MI Express Primary Care.

Information to be Released:

FROM TO _____

FROM TO _____

_____ Initials of Patient/Guardian

I understand that Umayr Azimi, MD may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient _____ Date _____ Signature of Witness _____ Date _____

A fax copy or photocopy of this consent shall be as valid as the original. If my medical records include information regarding drug abuse, alcoholism or alcohol abuse, or psychological/psychiatric conditions, I DO _____ DO NOT _____ authorize the release of this information except when services rendered for requested dates are authorized by employer for occupational medicine services whereby drug screen results and labs authorized by said employer will be shared with the employer.

** If this authorization is signed by an individual’s personal representative, the representative’s authority is based on _____ (e.g. state law, court order, POA, etc).

FEE SCHEDULE: State and Federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is \$1.19 per page for the first 20 pages. For pages 21-50, the fee is \$0.60 a page. For pages 50+, the fee is \$0.23 a page. No fee shall be charged for reproducing and forwarding records directly to other physicians. A \$23.71 initiation fee may be added in addition to the per page fee per Michigan Law to account for time and resources allocated to record distribution per discretion of MI Express Care or MI Express Primary Care.

FOR OFFICE USE ONLY

Physician Authorization: _____ Date Sent: _____ Via: Fax Mail Date: _____