Authorization to Release Medical Records (Clinic use only)
Date Received: _____ Pick Up:
Date Processed: _____ ○SF
Processed By: _____ ○DB
Patient ID#_____ ○ES
Paid $_____ Date Paid:_____By:
FAX
MAIL

LES I. SIEGEL, M.D., F.A.C.S.
MATTHEW E. CITRON, D.O., F.A.C.S.
MICHAEL J. SIEGEL, M.D., F.A.C.S.
FAISAL Y. RIDHA AL-TIMIMI, M.D.
SONIA W. RANA, M.D.

Name: _____ DOB: _____ Acct _____ Ph:

Email:_____ Home Address:

☐ **Copies Of Medical Records**: I request Glaucoma Center of Michigan to release my protected health information
Select Delivery Method: **(Additional Charge for Shipping & Supply Costs APPLY)**

☐ **Forms to be filled out:** I am the patient or the legal authorized representative and request Glaucoma Center of Michigan release my protected health (FORMS TO FILLED OUT BY PHYSCIAN $20)

IF RECORDS GOING ANYWHERE OTHER THAN THE PATIENT PLEASE FILL OUT HIGHLIGHTED PORTION:
Individual/Person_____Company/Organization_____

Address_____

Phone #_____ Fax #_____

Purpose of release/disclosure to other person/organization: (Circle)

Continuation of Care/Transfer of Care	Insurance Company	Attorney /Legal
Other (Specify)_____	Patient Request	Workman's Compensation

Type of record set to be released to party indicated above:

Key Clinical documentation (related to a specific surgery/incident/injury/illness)
from _____/_____/_____ to _____/_____/_____
All Clinical documentation (including history & physical, operative reports, consults, test reports, imaging, medications, etc)
from _____/_____/_____ to _____/_____/_____
OTHER Records (Please Specify) _____

Some fax and email transmission methods are not secure, and it is possible for PHI to be compromised during transmission from our practice. Do not include fax number or email address if this is of concern.
This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.
Please allow 7-10 business days for the process of this request. Medical Record fees are applied based on the Privacy Rule at 45 CFR 164.524 (c) (4).

_____

Signature of Patient/Legally Authorized Representative (If patient is a minor or unable to sign) Date:

_____

Printed Name of Legally Authorized Representative: