



MyCare Health Center

18 Market Street, Suite C, Mt. Clemens, MI 48043 P: 586.783.2222 F: 586.783.6280
6900 E. Ten Mile Road, Center Line, MI 48015 P: 586.756.7777 F: 586.756.7788
43740 Groesbeck Highway, Clinton Township, MI 48036 P: 586.493.0961 F: 586.493.1001

www.mycarehealthcenter.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: (First) (Middle) (Last) (Previous Name)
Address:
Date of Birth: Home Phone: Work Phone:
Social Security Number My Provider at MyCare is:

Release Records from MyCare Health Center To: (Name) (Address) (City) (State) (ZIP) (Phone) (FAX)
Release Records To MyCare Health Center From: [] Mt. Clemens [] Centerline [] Groesbeck (Name) (Address) (City) (State) (ZIP) (Phone) (FAX)

Reason for record request:

IMPORTANT - You may disclose health care information regarding testing, diagnosis, and treatment for (check yes or no):
() Yes () No HIV (AIDS virus)
() Yes () No Sexually transmitted diseases
() Yes () No Psychiatric disorders/mental health
() Yes () No Drug and/or alcohol use
Information to be released (be specific):
[] Last 2 years of records
[] Last 5 years of records
[] X-ray (specify dates)
[] Only dates of service from to
[] Other records (specify)

This authorization expires within one calendar year of being signed. If you wish to have the authorization expire before one calendar year please indicate the date of expiration:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing by sending such written revocation to MyCare Health Center at the above address. If I did, it would not affect any actions already taken by MyCare Health Center based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may inspect or copy (at additional expense) the information to be used or disclosed, as provided in CFR 164.524. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship (parent or legal representative)