MICHIGAN OTOLARYNGOLOGY SURGERY ASSOCIATES, P.C
MOSA-AUDIOLOGY
5333 McAuley Drive, Suite 2017 & 2016
Ypsilanti, MI 48197
800-851-6672
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Office Contact Person: Lisa Dover

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____ Chart # _____

Patient Address _____ Phone Number _____

I authorize the above named medical practice to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

Detailed description of the information to be released:

____ All records ____ All Test Results ____ Chart Notes ____ Audiology Records ____ Surgery/Hospital Notes

Any information relating to: _____

Time period Needed: Last ___ years **OR** From _____ to _____

To whom may the information be released? Name _____

Address _____

If not previously revoked by me in writing, this authorization is valid for one year after being signed. This authorization is signed to make medical information regarding me available to other parties.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office attention to Medical Records.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient _____ Print Name _____

Source of Authority _____