NEWLAND MEDICAL
ASSOCIATES, P.C.
www.NewlandMedical.com
Phone: (248) 552-0620

Authorization to Release Patient Health Information

Patient Name:_____ Date Of Birth:_____

Patient Address:_____
(Street) (City, State, Zip Code)

I hereby authorize: **Newland Medical Associates, P.C_____**

Address:

Phone Number: 248-552-0620
Fax Number:

to release patient health information to:

Name of Facility: _____

Contact person/title: _____

_____
Address

_____ _____
Phone Number **Fax Number**

Information to be released: From: _____ to _____
(dd/mm/yy) (dd/mm/yy)

- ○ Progress Notes
- ○ Laboratory Tests
- ○ All of the above
- ○ Outpatient Tests Reports
- ○ Radiology Reports
- ○ Inpatient Test Reports
- ○ Operative Report

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:

Yes, disclose this information: _____

No, do not disclose this information: _____

NEWLAND MEDICAL
ASSOCIATES, P.C.
www.NewlandMedical.com
Phone: (248) 552-0620

Purpose of this Release is:

- ○ Continuity of Care
- ○ Requested by Patient/Patient Representative
- ○ Other: _____

NOTICE

Newland Medical Asscoiates, P.C. and many other organizations and individuals such as hospitals, physicians and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Newland Medical Associates, P.C., 22301 Foster Winter Drive, 2nd Floor, Southfield, MI 48075. The revocation will take effect when Newland Medical Asscoiates, P.C receives it, except to the extent that Newland Medical Asscoiates, P.C. or others have already relied on it.

I am entitled to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION (may be a specific date or condition. If left blank, the authorization will expire 6 months from date below)

This authorization expires _____/_____/_____
(mm) (dd) (yyyy)

_____ Date: _____
(Signature of Patient or Patient's Legal Representative)

_____ Time: _____AM/PM
(Printed Name)

_____
(If signed by someone other than the patient, state your legal relationship to the patient)

_____
(Witness or Translator)

Authorizations signed by a legal representative must include a copy of the guardianship papers or a court certified power of attorney/personal representative document.