FRANKENMUTH MEDICAL ASSOCIATES

Medical Records Release Form

Patient Name _____ Date of Birth: _____

Address / ***Street Number*** _____

City, State and Zip Code _____ **Phone** _____

Social Security Number / ***Last 4 digits only*** XXX - XX- _____

RECORDS REQUESTED FROM:

Name of Person or Facility _____

Practice Address / *Street Number* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

RECORDS TO BE DISCLOSED TO:

Name of Person or Facility Frankenmuth Medical Associates

Practice Address / *Street Number* 154 S. Main Street, Suite 6

City, State and Zip Code Frankenmuth, MI 48734 Phone 989-502-1122

Fax 1 (844) 674-2260

Please select all the specific documents that apply to your request:

☐ All Notes and Consults ☐ Lab Reports ☐ Pathology Reports

☐ Hospital Records ☐ Radiology Reports ☐ Other _____

Please select the purpose of your request:

☐ Continued Patient Care ☐ Attorney/Legal ☐ Insurance ☐ Social Service/Disability

☐ Worker's Compensation ☐ Personal ☐ Other _____

Please send the records via:

☐ Mail to address above ☐ URGENT: Fax to number listed above

I understand that I may revoke this authorization any time. I understand that revocation of this authorizations will not apply to information that has already been released and that I must revoke this authorization *in writing* to Frankenmuth Medical Associates. I understand that I may refuse to sign this authorization and that my treatment cannot be conditoned upon my authorization of this disclosure. Unless otherwise revoked, this authorization will expire 1 year from the date of signature. ***My signature below confirms that I have read and understand the information in this authorization form and authorize the release of my medical records.***

_____

Patient Signature Date

_____

Printed Name of Patient

_____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

_____

Please explain Respresentative's authority to act on behalf of the Patient