



John D. Baker, MD
John D. Roarty, MD
Rajesh C. Rao, MD
Lisa I. Bohra, MD
Leemor B. Rotberg, MD
Elena M. Gianfermi, MD
Alexandra O. Apkarian, MD

RECORDS RELEASE

I AUTHORIZE AND REQUEST (*THE SENDER*):
(this is who you want to get records from)

DOCTOR'S NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

TO SEND ALL OF MY RECORDS TO (*THE RECEIVER*):
(this is who you want the records to go to)

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

By my signature, I authorize that my protected health information (PHI) may be used or disclosed by the sender. I authorize my PHI to be forwarded to the receiver. I understand that the PHI, which is used or disclosed pursuant to this Authorization, may be subject to re-disclosure by the recipient and may lose the protection of confidentiality under the privacy rules. I understand that I have the right to inspect and copy the PHI that will be used or disclosed pursuant to this Authorization. I understand that the sender and receiver will not condition any aspect of my treatment, payment, enrollment in the health plan or eligibility for benefits on whether or not I sign this Authorization. I understand that I am under no obligation to sign this Authorization. I understand this authorization will expire 60 days after the date I signed it. I understand that this Authorization may be revoked in writing at any time. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to the sender to use or disclose PHI in accordance to the terms of the Authorization.

PATIENT'S NAME (PRINTED): _____

PATIENT'S SOCIAL SECURITY #: _____ PATIENT'S DATE OF BIRTH: _____

PATIENT/PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN'S PRINTED NAME (IF APPLICABLE): _____

CLINTON TOWNSHIP
42700 Garfield Rd
Suite 200
Clinton Township, MI 48038
T 586.532.3380
F 586.416.1608

DEARBORN
22731 Newman St
Suite 245
Dearborn, MI 48124
T 313.561.1777
F 313.561.8044

WEST BLOOMFIELD
7001 Orchard Lake Rd
Suite 200
West Bloomfield, MI 48322
T 248.538.7400
F 248.538.7403

DETROIT
Children's Hospital of Michigan
Department of Ophthalmology
3901 Beaubien Blvd
Detroit, MI 48201
T 313.745.3937
F 313.745.0401