ANXIETY & DEPRESSION INSTITUTE

FAMILY CARE PHYSICIANS, P.C.

Marshall B. Sack, DO. & Associates
Family Medicine – Psychiatry

AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS INFORMATION

To: ______ Phone #: ______

Fax #: ______

I, ______, authorize Family Care Physicians, P.C. and Marshall B. Sack, DO.

to ☐ **release** ☐ **request** information contained in my medical records at the above listed physician, office, location or institution.

The medical information which may be disclosed:

☐ **all records.**

☐ **records limited to a specific period of time or concerning my illness and/or treatment of:**

______

● In accordance with Act 174, Section 5131, ☐ **I do authorize** ☐ **I do not authorize** the release of records regarding HIV infection, AIDS related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS) and/or serious communicable diseases.

● In accordance with Title 42 of the Code of Federal Regulations ☐ **I do authorize** ☐ **I do not authorize** the release of records regarding drug/alcohol abuse.

I authorize the method of release to be: ☐ **written via mail** or ☐ **electronic via fax/email**. (check box that applies)

The Physician, Facility and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized here. The recipient of the enclosed information is not authorized to use this patient's medical records for any other purpose than for that stated above or to disclose any information from the records to any other person or facility without specific written authorization from the patient or the patient's legal parent / guardian to do so. This authorization is only valid within 90 days of the patient's or parent / guardian's date of signature on this form. The patient may revoke this authorization at any time except to the extent that records have already been released pursuant to this release.

Patient Name: ______ Date of Birth: ______ Sex: ☐ **M** ☐ **F**

Address: ______ Phone #: ______

Signature: ______ Date: ______

Please Sign or Type Name to Electronically Sign.

*(Patient, Parent of a Minor Patient or Legal Guardian) *If legal guardian, a copy of court order appointing the guardian must be attached.

Witness Signature: ______ Date: ______

Please Sign or Type Name to Electronically Sign.

Please send records to the mailing address listed below. Thank you for your prompt consideration.

39500 West Ten Mile Road, Suite 100 ● Novi, Michigan 48375 – 2947 ● Phone #: (248) 476-0035 ● Fax #: (248) 476-2418