

## **Authorization For Use or Disclosure of Medical Record Information**

Med Rec #:
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Patient Full Name:			Date of Birth:		
Patient Address:			Home Phone:		
Dity:	State	Zip:	Work Phone:		
Release Informat	ion To				
hereby Authorize my	Health Care Provi	der to release my m	nedical record information	n to / obtain information from:	
lame/Facility:			Attention:		
ddress:			Phone:		
ity:	State	Zip:	Email/Fax:		
urpose of Request:				Preferred Output (paper is stan	dard)
Transfer from Practice	:/Reason?		Personal	O Paper O Electr	onic
Information to be					
<b>PY FEE:</b> Pursuant to Michi ichever is less.	igan Law, we reserve t	he right to charge a cost	based fee for patient requests	of \$25.00 or Michigan statute,	
Please provide a five yea	ar summary from my re	cords.		Comments	
Please provide my entire	,				
Other - please be specific	c, include dates and M	D's under comments.			
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statement, except to the extent that the Toledo Clinic has already completed action on it. \*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The Health Care Entity will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization.

<sup>\*\*</sup> If you are the legally recognized representative of the patient you must provide supporting documentation.