WESTERN WAYNE PHYSICIANS

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8338 Allen Rd, Suite 101, Allen Park, MI 48101
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Western Wayne Physicians

Address: 8338 Allen Rd, Suite 101

City: Allen Park State: MI Zip Code: 48101

This request and authorization applies to:

☐ Medical Records from: ☐ Oakwood Hospital ☐ Henry Ford Wyandotte Hospital
☐ Colonoscopy or EGD
☐ Pathology reports
☐ Major surgical summaries
☐ Last 3 years radiology reports
☐ Chronic Problem Lists
☐ Allergies
☐ Immunizations
☐ Other _____
☐ Other _____

I ACKNOWLEDGE that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed by them and no longer protected by the Privacy regulations.

I ACKNOWLEDGE that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I ACKNOWLEDGE that I may revoke this Authorization in writing at any time by contacting the disclosing party (WWP or other entity) except to the extent that action has been taken in reliance on this Authorization. This authorization expires 6 months from the date signed.

Patient Signature: _____ Date Signed: _____