WESTERN WAYNE PHYSICIANS

8338 Allen Road Suite 101 Allen Park, MI 48101
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Donna Angell M.D. | Jane Kramar M.D.
Robert Jackson M.D. | Deirdre Ryan P.A.-C.
Patricia Nester M.D. | Daniel Angell D.O.
Jennifer Garrett P.A.-C. | John McCracken M.D.
Stephanie Rea P.A.-C | Jenna Kleiber P.A.-C.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ D.O.B. _____

SSN (last four digits) _____

I request and authorize _____

(Name of Physician/Facility releasing information)

To release information contained in my records, including, as applicable: information about communicable disease and infections, as defined by statute and Michigan Department of Public Health rules, (which include venereal disease, TB, HIV and AIDS, Alcohol and drug abuse treatment information protected under regulations in 42 Code of Federal Regulations Part 2. Psychological services and social services information including communications made by me to a social worker or psychologist, to be sent to the individual indicated below:

Western Wayne Physicians

8338 Allen Road Suite 101

Allen Park, MI 48101

Attention: (please circle one)

Donna Angell M.D	Robert Jackson M.D.	Patricia Nester M.D.
John T. McCracken M.D.	Jane Kramar M.D.	Deirdre Ryan P.A.-C.
Daniel Angell D.O	Jennifer Garrett P.A.-C.	Stephanie Rea P.A.-C.
Jenna Kleiber P.A.-C.		

This request and authorization applies to:
Medical Records from:

- ☐ Oakwood (Beaumont) Hospital
- ☐ Henry Ford Wyandotte Hospital
- ☐ Colonoscopy and/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/Guardian Signature: _____ Date:_____