HOMEMD
HOUSECALL SERVICES

Authorization for Release of Health Information

Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I.: Date of Birth:

Release Information From (Required):

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

HomeMD Housecall Services
Attn: Medical Records Dept.
5758 Cooley Lake Road
Waterford, MI 48327

FAX: 810-244-0226 PHONE: 855-466-3631

Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

☐ Notes from **four** most recent provider visits ☐ Labs and imaging within last two years

☐ Hospital discharges within **last two years** ☐ Other: _____

By law, you must specifically request the following information for it to be released:

Chemical dependency program: ☐ Yes ☐No Behavioral health notes: ☐ Yes ☐No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to HomeMD Housecall Services. I understand that if I revoke this authorization, it will not have any effect on any actions taken by HomeMD Housecall Services before receiving my revocation. This release covers past, present and future encounters/visits and does not expire unless I provide a written notice with the date of requested discontinuation.

I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from HomeMD Housecall Services as a Legal Representative for the patient, I hereby release and hold harmless HomeMD Housecall Services and its representatives from any claims or damages arising from HomeMD Housecall Services reliance on my attestation that I am Legal Representative.

_____ _____

Patient or Legal Representative Signature ***Date***

_____

Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

Fax completed forms to: 810-244-0226