Request For Medical Records

Patient's Complete Name: Last: ________________ First: ________________ Middle: ________________

Date of Birth _______/_______/_______ Last 4 digits of Social Security Number: xxx – xx - __________

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
	Tree of Life Wellness / Dr Kristina Bahrou
Organization	Organization / Person
	3830 Packard St Suite 230 Ann Arbor, MI 48108
Street Address City, State, Zip	Street Address Box City, State, Zip
	734-330-2110 734-800-4524
Phone Fax	Phone Fax

INFORMATION TO BE RELEASED

Format for records (please check ONLY one box): ☐ **FAX** ☒ **PAPER** ☒ **CD** ☐ **OTHER**

Dates of service for records requested: Beginning __________________________ **Thru**__________________________________

☒ Pertinent Information (Discharge Summary, H&P, X-Ray, Lab, Operative, Consults)
☐ Complete Medical Record
☒ Clinical Information/Notes
☒ Discharge Summary
☐ Other (please specify)____
☐ Immunization Records
☒ Lab Report
☒ Pathology Report
☒ Operative Reports
☐ Emergency Room/Urgent Care
☒ Imaging Results

PURPOSE OF RELEASE

☐ Continuation of Care ☐ Other____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:
(1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or healthcare provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my healthcare, the payment for my healthcare or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose.
Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified _________________.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **AIDS/HIV Related** ☐ **Alcohol/Drug Abuse Treatment**
☐ **Psychotherapy Notes** ☐ **Sickle Cell Anemia** ☐ **Genetic Testing**

This form must be filled out completely in order to obtain medical records

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

____
Signature of Patient or Legal Representative Date (month/day/year)

____
Relationship to patient, if not signed by patient