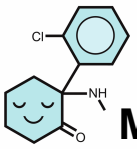

Michigan Progressive Health

Megan Oxley, MD

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Ann Arbor: 2300 Washtenaw Ave., Suite 100 Ann Arbor, MI 48104 **Ph:** 734.585.5587 **Fx:** 248.439.0515

Authorization to Release / Obtain Medical Records

Patient Name:_____ Date of Birth:_____

Preferred Phone:_____

I hereby authorize Michigan Progressive Health (MPH) Medical Providers and Therapists to:

☐ Release Personal Health Information (PHI) from my medical records to (This allows MPH to send your written chart to):

☐ Obtain PHI from my medical records from (This allows MPH to receive your written chart from):

☐ Share PHI relevant to my treatment with (This allows MPH to have written or verbal conversations about your care with):

Name:_____Phone:_____Fax:_____

Address:_____

Dates of Service:

☐ All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults And neuroimaging reports. This does not include any records designated as psychotherapy notes. _____

☐ Medication records only ☐ Labs and imaging studies only ☐ The following specific info only: _____

Purpose of Disclosure:

☐ Coordination of Care ☐ School / College ☐ Family Member Access to Treatment
☐ Consult/Second opinion ☐ FMLA / Disability ☐ Insurance application (e.g., long-term care)
☐ Transfer of Care ☐ Other: _____

1. I understand that this authorization will expire one year after I have signed this form, or as specified here:_____
2. I understand that I may revoke this authorization at any time by notifying Michigan Progressive Health or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

_____ _____
Signature of Patient Date

_____ _____
Print Name

_____ _____
Parent/Legal Guardian/Authorized Person Date

Please send to:

Megan Oxley, MD
Michigan Progressive Health
Fax: 248.439.0515
Email:
royaloak@michiganprogressivehealth.com
annarbor@michiganprogressivehealth.com