



Complete Care Center
 8401 Holly Road
 Grand Blanc, MI 48439
 810.695.8011 Fax: 810.695.8002

AUTHORIZATION FOR ACCESS TO AND RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Acct #: _____

Address _____ City _____ State _____ Zip _____

1. I, _____, give my consent to Complete Care Center to

Check One: Release Records To or Receive Records From

Name/Facility _____
 (Please list the name of the facility that CCC is receiving records from or sending records to)

Address _____

3. **In order to verify your identity, please complete two (2) of the following:**

1. Birth date _____ 2. Social Security #: _____

3. Home Phone _____ Work Phone: _____

2. **Information to be released:**

Date(s) of Service _____

Please Circle: (D.O.S. is Date of Service)

➤ Entire Medical Record All Records for D.O.S. Testing for D.O.S. Transcription for D.O.S.

Please Check appropriate line(s) and fill in name:

➤ _____ I authorize Complete Care Center to release his/her entire medical record **excluding** information related to **HIV infection or AIDS** and the following (if applicable)

➤ _____ I authorize Complete Care Center to release medical information **related to HIV infection or AIDS.**

5. **Purpose of Release:**

_____ Medical Care _____ Insurance _____ Personal Information _____ Other

If Other, what is the purpose: _____

6. This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above listed Physician or Facility. A photocopy of this authorization shall constitute a valid authorization.

If deemed necessary by Complete Care Center, I authorize this information to be sent via facsimile (fax) transmission.

The physician, facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that there may be fees associated with the copying and postage of this record and understand that receipt of this record **may be denied** until fees are paid in full.

 Patient or Representative

 Date

 Relationship to Patient

For Office/Privacy Contact use only

Request Received On: _____ Date _____ By: _____ (Name)

Upon reviewing patient's Request for Access to Records, Complete Care Center:

____ Agrees to Patient's Request for Access to Records

____ Does not agree to Patient's Request for Access to Records

COMMENTS: _____

PRIVACY CONTACT SIGNATURE

DATE

Medical Records Access Manager:

Request received: _____ Total of fees: _____ Payment received: _____

Date Request completed: _____