Rosewood
HEALTHCARE
& MEDICAL SPA

Patient Authorization to Release Medical Information

Please Release Any/All Requested Records To:

Rosewood Health Care
2480 Rosewood Drive North
Mt Pleasant, Michigan 48858
Phone (989) 775-3823
Fax (810) 275-0307

I authorize Rosewood Health Care to use or disclose my identifiable health information as described below. I understand the information may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that this information may be sent via fax transmission. This authorization will expire in 1 year from the date of signature, but I may revoke my consent at any time by written notice.

Medical Information to be Sent:

_____ Entire Medical Record, INCLUDING information relating to the treatment for substance abuse or dependence, psychiatric or mental health treatment; information related to testing or the treatment of HIV/AIDS.

_____ Entire Medical Record, EXCLUDING information relating to the treatment for substance abuse or dependence, psychiatric or mental health treatment; information related to testing or the treatment of HIV/AIDS.

_____ Specific Medical Information to be used or disclosed, please describe documentation requested in detail:

_____

_____

_____

_____

_____

Requesting Records from(name of clinic/provider)_____

Address of Clinic/Provider_____

Phone Number: _____ Fax Number: _____

Patient Name:_____ Date of Birth: _____

Patient of Parent/Guardian Signature:_____

Relationship to Patient: _____ Date:_____