AUTHORIZATION AND CONSENT TO OBTAIN AND RELEASE INFORMATION

Patient Name: ________________________________ Date of Birth: ________________

I hereby authorize my Medical Records to be released **to/from** Michigan Spine & Pain. This information to be released is to be used only for the following authorized purpose:

- **Planning and Management of Medical Care**
- **Payment of Services by a Third Party Payor**
- **Purposes of Litigation with Michigan Spine and Pain Counsel**

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- *This Release of Information will remain in effect until terminated by me in writing.* I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Please list responsible parties who may receive your health information. (Spouse, mother, child, Nurse Case Manager, etc.) Please provide name and relationship below:

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If unable to reach me:
[ ] you may leave a detailed message regarding appointment reminders, test results, general messages
[ ] please leave a message asking me to return your call.
[ ] other ____

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

______________________________________ ____________________

Signature Date

***PLEASE READ** Fee Information*:* **Michigan Spine and Pain** contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy. DataFile Technologies: 816-437-9134 www.datafiletechnologies.com

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