Dr. Joe Gorz
1261 S Lapeer Rd, Ste 202
Lake Orion, MI 48360
T: 248-690-9181 F: 248-690-9675

Medical Records Release

Patient Name: _____ Patient DOB: _____

Previous Name: _____ Daytime Phone: _____

I _____ request and authorize Neighborhood Primary Care (NPC) to obtain records from:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

You may disclose the following health care information (Check all that apply):

□ Chart Notes (Last 2 or all)	□ Labs/ Pathology	□ X-rays/ Diagnostics
□ EKG	□ Medication List	□ PAP/ Colonoscopy/ Mammogram
□ Patient Visit Summary	□ Growth Chart	□ Most Recent Specialist(s) Visit
□ Last Well Child Check	□ Billing	□ Medicare Annual Wellness Visit
□Immunizations	□ All Records	

Other: _____ Time Frame Requested: _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/ disclosed under this authorization. I have authorized for NPC to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to NPC, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

Specific Authorization

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked NO and initialed it.

____ Yes ____ No _____ Initials

_____ _____ _____

Signature/Legally Responsible Party | Relationship to Patient | Date