JAJO
PSYCHIATRY

6450 Farmington Road
West Bloomfield, MI
48322

Phone: 734-331-6037
Fax: 734-331-6260

AUTHOIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

PATIENTS NAME: _____ PHONE: _____

ADDRESS: _____

SOCIAL SECURITY # (LAST 4) _____ D.O.B: _____

I AUTHORIZE JAJO PSYCHIATRY, TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING:

PHYSICIAN/ORGANIZATION:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

NOTES: _____

I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED ON IT. REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED BY THIS AUTHORIZATION OR TO MY INSURANCE COMPANY.

I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE BY THE RECIPIENT & THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

_____ _____

PATIENT OR PATIENT REPRESENTATIVE SIGNATURE TODAY'S DATE

_____

REPRESENTATIVE'S NAME (PRINT) RELATIONSHIP TO PATIENT

◯ I DECLINE SHARING MY PCP INFORMATION.