# Medical Records Release Form

| | |
|---|---|
| Date: | |
| Participant Name: | |
| Date of Birth: | |
| Address: | |
| Phone Number: | |
| Email Address: | |

| | |
|---|---|
| Person Requesting the Information (e.g. self, personal representative, etc.) | |
| Address: | |
| Phone Number: | |
| Email Address: | |
| Relationship to Participant: | |

The information you may release subject to this signed release form is as follows (Please be sure to indicate the timeframe for request):

☐ Complete Records (please indicate timeframe
☐ Initial Assessment
☐ Reassessment
☐ Person Centered Service Plan (Treatment Plan)
☐ Person Centered Service Plan (Services)
☐ Emergency Backup Plan
☐ Medication Record
☐ Progress Notes
☐ Other (please specify):

Medical Records are to be release to the following physician/facility/person and/or those directly associated with my health care:
Name:
Address:
Phone Number:
Email Address:

**The purpose of this release of information is as follows:**

_____ _____
Participant/Representative Name (Printed) Date

_____ _____
Participant/Representative Signature Date

**The release can be revoked at any time in writing and is effective until one year from the date of the signature. If you have any questions please contact:**

**Privacy Officer**
**The Information Center 20400 Superior Rd. Taylor, MI 48180 734-287-7818**