Marko Habekovic MD
Ophthalmology

Authorization
RELEASE OF MEDICAL INFORMATION

Patient name _____ Date of birth _____

Maiden name _____

Phone _____ Last 4 digits of Social Security number _____ (optional)

Address _____

City _____ State _____ Zip _____

RECORD RELEASE

I authorize my records to be sent FROM:

Name/Organization _____

Address _____

City _____ State _____ Zip _____

I authorize my records to be released TO:

Name/Organization _____

Address _____

City _____ State _____ Zip _____

INFORMATION REQUESTED

- ☐ Abstract record
- ☐ Consults
- ☐ Discharge summary
- ☐ EEG/ECG/EMG
- ☐ Emergency record
- ☐ History and Physical
- ☐ Immunization record
- ☐ Lab reports
- ☐ Office visit
- ☐ Procedure reports
- ☐ Pathology reports
- ☐ Psychotherapy notes
- ☐ Pathology slides
- ☐ Radiology reports
- ☐ Other _____
- ☐ Inspection only
- ☐ Billings, invoices and statements
- ☐ Records related to specific problem of _____

RADIOLOGY IMAGES ONLY

Films to be released/From specific dates

X-ray	CT Scan	MRI	Nuclear	Ultrasound	Interventional Radiology
☐ Images	☐ Images	☐ Images	☐ Images	☐ Images	☐ Images
☐ Reports	☐ Reports	☐ Reports	☐ Reports	☐ Reports	☐ Reports
☐ Both	☐ Both	☐ Both	☐ Both	☐ Both	☐ Both
Dates:	**Dates:**	**Dates:**	**Dates:**	**Dates:**	**Dates:**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

OVER →

DO NOT MARK BELOW THIS LINE

DO NOT MARK BELOW THIS LINE

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

PURPOSE OF DISCLOSURE

☐ Patient request ☐ Attorney/Legal ☐ Insurance ☐ Continued Patient Care
☐ Other (specify) _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person, except as required by law. I further understand that correspondence, patient discharge instructions and records from other health care providers will be released with this routine request. I also acknowledge that Marko Habekovic MD PLLC assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Marko Habekovic MD PLLC provider.

If you *DO NOT WANT* to release any of your specially protected information in the categories below, check the box(es) for that category:

☐ Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules, which include venereal disease "VD", tuberculosis, "TB", hepatitis B, human immunodeficiency virus "HIV", HIV test, acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC" and _____ (specify other if known).

☐ Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.

☐ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

☐ The release of my DNA test result regarding a diagnosis of _____ (Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

This authorization will expire sixty (60) days from the date of my signature, unless I specify otherwise:

_____

This authorization may be revoked in writing at any time as outlined in Marko Habekovic MD Notice of Privacy Practices. Marko Habekovic MD does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits. There is potential that information disclosed under this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA).

However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and also by Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form

TIME _____ **DATE** _____ Patient or Legal Representative signature _____

Basis of legal authority to act for patient _____

TIME _____ **DATE** _____ _____
Witness

TIME _____ **DATE** _____ _____
Second Witness *(required if witness is unable to sign or gives verbal permission)*

Identification (ID) checked? ☐ Yes ☐ No Completed by _____
Copies were: ☐ Mailed ☐ Picked up (print staff name)