



Total Health & Wellness Associates, PLLC

Bringing it all together... Mind, Body & Spirit

Mailing Address: PO Box 3052 • Farmington Hills, MI 48333-3052
Phone: (734) 368-7154 • **Fax:** (248) 477-4442

Office Locations

31700 W. 12 Mile Road
Suites 100 & 250
Farmington Hills, MI 48334

245 Barclay Circle
Suite 400
Rochester Hills, MI 48307

1025 E. Maple Road
Suite B-7A
Birmingham, MI 48009

432 N. Saginaw Street
Suites 415 & 433
Flint, MI 48502

Authorization to Release Patient Information

Patient Name: _____

Patient Phone: _____

Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information as described below:

The type and amount of information to be used or disclosed as follows:

- Diagnosis
- Medication List
- Entire Record
- Other: _____

This information may be disclosed to and used by the following individual or organization:

Address: _____

Phone/Fax: _____

For the purpose of: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Total Health & Wellness Associates Business Administration Office. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information to the individual or organization named above is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact a representative of Total Health & Wellness Associates at (734) 368-7154.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient or Personal Representative Signature

Date

If you are signing this form as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ **Print Name:** _____

Source of Authority (attach relevant documents as applicable): _____