Total Health & Wellness Associates, PLLC
Bringing it all together… Mind, Body & Spirit

Mailing Address: PO Box 3052 ● Farmington Hills, MI 48333-3052
Phone: (248) 957-6444 ● Fax: (248) 477-4442

Office Locations

23580 Orchard Lake Road
Farmington Hills, MI 48336

245 Barclay Circle, Suite 400
Rochester Hills, MI 48307

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

Primary Care Provider Collaboration
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: _____
- ☐ **ALTERNATIVELY, do NOT communicate with my PCP**

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

Primary Care Provider Name: _____

Address: _____

Phone/Fax: _____

For the purpose of collaboration of care between my behavioral health/integrative provider(s) at this practice and my PCP.

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): _____