COMMERCE PRIMARY CARE **248.363.7500**
8800 Commerce Road **248.363.7700 fax**
COMMERCE, MI 48382

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Commerce Primary Care to obtain and/or disclose any health information with other physicians/facilities that I may be referred to, as well as physicians/facilities I have been to in the past.

Patient's Name:
_____D.O.B._____

Your previous doctor's name and phone or fax number:

_____

Specific description of information to be released:

LAST 3 YEARS OF: **LABS, CONSULTATIONS, & DIAGNOSTICS (XRAYS, ETC.)**

Purpose of the use or disclosure: continuity of medical care.

The Patient or Patient's Representative must read and initial the following statements:

I understand that:

a.) My health care and the payment for my health care will not be affected if I do not sign this form

b.) I may see and/or have a copy of the information described on this form and the form itself after I sign it.

c.) I may revoke this authorization at any time by notifying the providing organization in writing. However, it has no effect on any actions they took before they received the revocation.

_____ _____

***Signature* of Patient or Patient's Representative** Date:

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
HOWEVER, THIS WILL DELAY OUR EFFORTS TO RETREIVE RESULTS, ETC.