MICHIGAN RHEUMATOLOGY
AND WELLNESS CENTER, PLC

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REQUEST FOR OUTSIDE RECORDS - PATIENT INFORMATION FORM FROM ANOTHER ORGANIZATION

Patient Name: _____ DOB: _____

Street Address: _____

City/State/Zip: _____ Tel: _____

Email Address: _____

1. I hereby authorize the release of information from following Doctor/ Clinic/ Unit:

Name of Person/Organization: _____
Street Address: _____
City/State/ Zip: _____

Send information to:
ATTENTION (Name): _____ Phone #: _____
Address: _____ Fax #: _____
City/State/ Zip: _____

2. Specific Information Needed: From Dates of Service: ____/___/_____ to ____/___/_____
(mm/dd/yyyy) (mm/dd/yyyy)

I request to the following information to be released, which may include alcohol and drug abuse/treatment: psychological and social work counseling; HIV or AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; and demographic information, for the purpose and the conditions designated on this form.

- ☐ **Inpatient Record**
- ☐ **Outpatient Record**
- ☐ **Operative Report**
- ☐ **Consults**
- ☐ **Treatment Summary**
- ☐ **Discharge Summary**
- ☐ **Emergency Room Record**
- ☐ **Entire Medical Record**
- ☐ **Laboratory Tests Results**
- ☐ **Pathology**
- ☐ **X-Ray – Imaging Films/CD**
- ☐ **X-Ray – Imaging Reports**
- ☐ **Other (specify):** _____

SIGNATURE: _____ DATE: _____