New Horizons Medical Center, P.C.
19335 Merriman Road
Livonia, MI 48152
Tel: 248-474-4900
Fax: 248-474-3278

Sean P. Coyle, M.D.
Sheryl Conn, M.D.

Chuck Yadmark, M.D.
Khalil Nahra, M.D.

MEDICAL RECORD AUTHORIZATION

PATIENT NAME: ______________________ DATE OF BIRTH: __________

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: __________

I, ______________________ authorize ______________________ to release all information contained in my medical records, including, as applicable;
1) Record of treatment of drug and/or alcohol dependency or abuse;
2) Mental health treatment records, psychological services and social services information, including communications made to me by a social worker or psychologist;
3) Information about Human Immunodeficiency (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS related Complex (ARC).

Release my medical records to:

New Horizons Medical Center, P.C.
19335 Merriman Road
Livonia, MI 48152
Tel: 248-474-4900 Fax: 248-474-3278

(Please initial) _____Any and all of my medical records except the following: ______________________

____

This information is being released for the following purpose(s) only: ______________________

____

This release is effective for six months from date of execution, however, may be revoked by me at any time by providing notice in writing to the above named party.

Signature: ______________________________ Date ______________

Witness: ______________________________ Date ______________

WRITTEN STATEMENT: PROHIBITION AND REDISCLOSURE

This information has been given to you from records protected by Federal Confidentiality Rules (42CFR). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.