The Heart + Wellness Institute
Delivering compassionate world-class care.

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth (m/d/y): _____-

Address: _____ City: _____ State: _____ Zip: _____

Patient Phone #: _____ ♦ Patient Email Address: _____

**Provider Authorized to Release the Information:**

Heart & Wellness Institute—Prerana Manohar M.D.—Vinayak Manohar, M.D.
Address for Record Requests: P.O. Box 688 7125 Headley St SE Ada, MI 49301
Web Address for Record Information:www.heartwi.com

**Party Requesting (check one):** ___Patient or Authorized Representative ___Other (Specify): _____

If "Other," specify purpose: _____

**Organization or Person Authorized to Receive the Information:**

Name _____

Address: _____ City: _____ State: _____ Zip:_____

Phone #: _____ ♦ Facsimile #: _____

**Information to be Released (in either oral or written form):**

A. I authorize and request the release of the following information (select only one of the following):

☐ All information pertaining to any treatment received (i.e., complete record).

[Optional] Except: _____

☐ Only the following records or types of health information (including any dates):_____

_____

B. I specifically authorize and request the release of the following information (check all that apply):

☐ Mental health treatment information

☐ HIV/AIDS related information

☐ Alcohol/drug treatment information

**Notice of Rights and Other Information:**

- This authorization will expire six months from the signature date. I can, however, revoke this authorization in writing at any time, except to the extent that the provider authorized to release the information has relied on it.
- I have a right to receive a copy of this authorization.
- I may refuse to sign this authorization.
- Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may be no longer be protected by federal privacy law (HIPAA).

**Signature:**

Signature of Patient or Legal Representative: _____ Date: _____

_____

If signed by someone other than the patient, print name and state legal relationship to patient