Charles G. Godoshian, M.D., F.A.C.P.
27177 Lahser Rd., Suite 104 Southfield, MI 48034
TEL 248-353-0882 FAX 248-353-0883

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____ Date of Birth_____

Social Security #_____ Maiden/Other Name_____

Patient Address_____
Street City State Zip

Phone Number_____

I authorize _____ to release information contained in my
Healthcare Facility/Physician
medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).

Name to whom information may be released: Charles G. Godoshian, M.D.

27177 Lahser rd Suite 104 Southfield, MI 48034
Address City State Zip

248-353-0882 248-353-0883
Telephone Number Fax Number

Specific Type of Information to Be Disclosed

Discharge Summary	X-Ray Reports	Other (specific)_____
History & Physical	X-Ray Films	_____
Consultations	Operative Reports	
Laboratory Results	Pathology Report	Date(s) of Treatment_____

Purpose and Need for Such Disclosure:

_____

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a Statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payments based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subjected to re-disclosure by the recipient and may be no longer protected.

_____ _____
Signature of Patient/Parent/Personal Representative Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

_____ _____
Print Name Relationship/Authority Source

********** PLEASE NOTE: THERE IS A FEE FOR COPYING MEDICAL RECORDS **********