Corrigan
record storage

Medical Records Release Form

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Physician Name_____

Patient Name_____

Date of Birth_____

Address_____

City, State, Zip Code_____

Home Phone_____ Other Phone_____

I understand that my or my child's medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing) and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____ _____

(Patient signature) (Signature of parent/guardian if patient is a minor)

_____

(Date)

Please fax, email or mail completed form to Corrigan Record Storage.

Corrigan Record Storage
45200 Grand River Ave. Novi, MI 48375
Phone: 248-344-9185
Fax: 248-344-9159
Email: corriganrecords@corriganrecords.com