

**MEDICAL AUTHORIZATION FOR RELEASE OF
MEDICARE RECORDS FROM NATIONAL
GOVERNMENT SERVICES
FREEDOM OF INFORMATION UNIT**

This authorization or photocopy hereof, will authorize to disclose to **Minute Man Services, Inc., 3318 N Main St, Royal Oak, MI 48073**, all information you may have concerning _____, with respect to any illness, injury, medical history, consultation, prescriptions, treatments, x-ray plates, itemized bills and copies of all hospital and medical records. This includes alcohol and drug abuse records protected under 42 Code of Federal Regulations, Part II, any psychiatric/psychologist and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Dept of Public health /community health rules which includes venereal diseases, tuberculosis, HIV, AIDS, ARC (MCL 333.5131)

I understand the following: see CFR§164.508(c)(2) (i-iii)

- A. I understand I have the right to revoke this authorization in writing at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released
- B. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law..
- C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

MEDICARE # _____

NAME OF PATIENT _____

SIGNATURE OF PATIENT, PARENT OR
GUARDIAN OR ADMINISTRATOR OF ESTATE

DATE

WITNESS