Grunberger Diabetes Institute

43494 Woodward Avenue
Suite 208
Bloomfield Hills, MI 48302
248-335-7740
248-338-7979 Fax

Medical Record Release

Patient Name: _____

Address: _____ Phone: _____

DOB: _____/_____/_____

I request and authorize the release of my protected health information (as directed below):

From: Grunberger Diabetes Institute
Name of Physician/office
43494 Woodward Avenue, Suite 208
Address
Bloomfield Hills, MI 48302
City, State, Zip
248-335-7740 248-338-7979
Phone Fax

To: _____
Name of Physician
_____
Address
_____
City, State, Zip
_____
Phone Fax

Information contained in my medical records, including alcohol and drug abuse records are protected under the regulations, 42 code of Federal Regulations (CFR) Part II, as well as psychological service records/psychiatric records, if any. The specific nature or extent or information to be disclosed is:

- ❑ Entire record since _____/_____/_____
- ❑ Laboratory tests
  (please specify) _____

This health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

- ❑ Change in Endocrine Physician
- ❑ Insurance Change
- ❑ Primary Care Physician
- ❑ Referral Physician/Second Opinion
- ❑ Moving/New Address
- ❑ Life Insurance Disability

This authorization is effective on the date of signature for 60 days unless revoked by me in writing.
Please note: A processing fee may be assessed for the release of your records per the State of Michigan Medical Record Access Act. This payment is due upon receipt of records.

Patient Signature: _____

Parent/Guardian (if patient is a minor): _____

Date: _____ Witness: _____