Karle Medical Group, P.C.
455 Barclay Circle, Suite D
Rochester Hills, MI 48307
T: 248-852-9596 | F: 248-852-9453

Christine L. Karle, D.O Bridget C. Karle, M.D. Kristie Burkland, N.P.C. Denise Gavorin, D.O.
Rabia A. Cacco, M.D. Tracey R. Ticcony, N.P.C. Malaz Alatassi, M.D Molly Bylsma, N.P.C. Amir Sankari, M.D.

Medical Records/Information Release Authorization Form

Receiving Entity: Under HIPAA Title 45, Section 164.506, there is no need for us to send a patient or physician-signed release of information to obtain records. It is a violation of HIPAA to refuse a request on that basis.

Patient Name: _____ Patient DOB: _____ Karle Physician: _____

To (Entity **releasing** medical records):

☐ I am going to be seeing a Primary Care physician **not** affiliated with the Karle Medical Group either **permanently** or for a **fixed-interval** (e.g., Going to Florida for the winter).

Name: _____

Address: _____

_____

Phone: _____

Fee for Medical Records from KMG

Initial Fee: $26.65

First 20 pages / $1.27 per page
Pages 21 – 50 / $0.63 per page
Pages 51 and over / $0.25 per page

Shipping Fee: $7.50 - $25.00

Patient Authorization

I. **My Authorization**: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol and drug abuse.

☐ All healthcare information in my medical record ☐ other: _____

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____

City, State & Zip Code: _____Phone: _____

Reason(s) for the authorization (Check all that apply):

☐ Leaving Practice ☐ Specialist ☐ Insurance Request ☐ Other: _____

Patient Rights

II. **My Rights**: Authorizing the disclosure of this Health Information is voluntary. I can refuse to sign this authorization. I do not have to sign this authorization in order to assure treatment. I may revoke this authorization in writing. If I do, it will not affect prior action taken by Karle Medical Group based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke authorization: A Karle Medical Group Revocation form must be filled out. Once healthcare information is disclosed the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. Karle Medical Group in cannot be held liable for a third party's actions.

I would like a copy of this authorization. ☐ Yes ☐ No

If you understand and comply with all of the above policies, please sign below.

_____ _____ _____
Print full name Signature Date

_____ _____ _____

Please return this document to the Karle Medical Group reception desk upon completion.

Karle Medical Group, P.C.
455 Barclay Circle, Suite D
Rochester Hills, MI 48307
T: 248-852-9596 | F: 248-852-9453

Christine L. Karle, D.O Bridget C. Karle, M.D. Kristie Burkland, N.P.C. Denise Gavorin, D.O.
Rabia A. Cacco, M.D. Tracey R. Ticcony, N.P.C. Malaz Alatassi, M.D Molly Bylsma, N.P.C. Amir Sankari, M.D.

Witness Signature Date

Please return this document to the Karle Medical Group reception desk upon completion.