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

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 | Katie Brubaker, N.P.C.

Medical Records/Information Release Authorization Form

The Karle Medical Group requests that you sign this form. We will seek to acquire care-relevant documents from all of your healthcare providers on an as needed basis. Because we are your primary care provider, this authorization should not be necessary, but we have found that some healthcare entities demand such a form. In order to provide you with optimal care, we ask that you authorize us to use the form with any/all healthcare entities who demand a signed authorization.

Patient Name: _____Patient DOB: _____ Karle Med. Grp. Physician: _____

Non-Karle Medical Group Doctor's Office Information (Entity **releasing** medical records):

- This form authorizes my primary care office, The Karle Medical Group, to acquire medical records from any and all of my healthcare providers and healthcare institutions.
- You may disclose all healthcare information in my medical record including, but not limited to, office-visit notes, all results of diagnostic testing, and procedure and surgical notes to the Karle Medical Group.
- A completed copy of this authorization will be retained in my electronic health record.

Doctor Name: _____

Doctor's Office Address: _____

Doctor's Office Phone: _____ Doctor's Office Fax: _____

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.

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Reason(s) for the authorization: Continued medical care

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.

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.

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