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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________________DOB___________

I request and authorize Oakland Arthritis Center to release healthcare information of the patient above to:

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Patient Signature: ______________________________Date: _____________

We recommend a copy of the first and last office visit, a copy of recent labs and x-ray results.

We can provide this for a fee of $5.00 _______ **Initial here.**

If you prefer a copy of your entire chart charges will apply. _______ **Initial here.**

THE MEDICAL RECORDS ACT FROM THE STATE OF MICHIGAN: STATES PATIENTS MAY BE CHARGED FOR COPIES OF THEIR RECORDS. CHARGES ARE AS FOLLOWS:

PER PAGE FOR THE FIRST 20 PAGES $1.45

PAGES 21-50 $0.72

PAGES 51+ $0.29

After the completion of this form and payment is received, we will forward your records.