MEDICAL RECORDS RELEASE INFORMATION

This document requires a NOTARIZED signature from the patient, legal guardian, or power of attorney to release medical records. Notarizations can be obtained at County Clerk offices, insurance companies, Credit Unions, or law offices.

Alternatively, the patient can request the records in-person at the Emergent Health Partners headquarters in Ann Arbor, MI. Photo ID is required for in-person records collection.

A notarized document is a document that has been certified by a Notary Public. The Notary Public is an official who verifies the identity of individual signing a document, witnesses the signatures, and marks with the document with a seal.

Obtaining Records
Patient: fill out the request authorization form complete with a notarized signature.

Minor child: along with notarized authorization form, a copy of the minor’s birth certificate must be presented.

Legal guardian of patients 18+: if the patient is not their own legal guardian, along with a notarized authorization form, a copy of proof of power of attorney must be presented.

Deceased patient: along with notarized authorization form, a copy of the death certificate and proof of power of attorney must be presented. A valid photo ID matching the patient’s name and date of birth on the death certificate will also suffice.

Please return completed authorization forms to:
Emergent Health Partners
Attn: Michelle Knott
1200 State Circle
Ann Arbor, MI 48108

If you would like to pick up records in person, please call to arrange a time:
Michelle Knott, Patient Accounts Representative
734-477-6366

All records requests submitted by mail will be processed within 30 days.
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date of request: ________________________________

Patient name: ____________________________________________ Date of birth: ________________________________

Date(s) of service: ____________________________________

Specific records for which access is requested: ____________________________________________________________

_____________________________________________________________________________________________________

Requesting to:   [ ] See the records
                 [ ] Receive a copy of the records
                 [ ] See and receive a copy of the records

I, the undersigned, hereby authorize EMERGENT HEALTH PARTNERS to show or release protected health
information (PHI) on the patient listed above to the following parties: ___________________________________

_____________________________________________________________________________________________________

By signing this document, I authorize a copy of this form to be used with the same effect as an original.

______________________________________________________  Date
Patient Signature

______________________________________________________  Date
Parent/Legal Guardian Signature

______________________________________________________  Date
For deceased patient: Personal Representative Signature

Mail or fax documents to:
Address: ____________________________________________ City/State/Zip: ________________________________

Fax #: ____________________________________________ Contact Phone #: ________________________________

THIS DOCUMENT MUST BE NOTARIZED

Notary Public - place seal in this area
Subscribed and sworn to me on: ________________________________

______________________________________________________  Commission Expires
Notary Public Signature