Specialists In Rehabilitation Medicine, P.C.

Physical Medicine • Rehabilitation
Sports Medicine • Carpal Tunnel
Electromyography • Back Pain
Acute Pain Management
Occupational Medicine
Interventional Pain Medicine

Shawn Achtman, DO‡
Melissa Andric, DO‡
Steven Arbit, MD‡±
Craig Hysni, MD‡
Krisztina Mishack, MD‡
Brian Roth, MD‡±
Chris Schoenherr, MD‡*

Lori Broecker, ANP-BC≈
Erica Christy, PA-C
Molly Maki, AGNP-BC
Sara Miller, FNP-C
Melissa Niemiec, ANP-BC≈
Anne Smith, NP-C≈

Board Certified

‡American Board of Physical Medicine & Rehabilitation

±American Board of Electrodiagnostic Medicine

*Subspecialty Sports Medicine

≈Certified Rehabilitation Registered Nurse

Preferred Mailing Address:
9640 Commerce Road, Suite 202
Commerce Township, MI 48382
PHONE: (248) 360-8660
FAX: (248) 360-9235

10 W. Square Lake Road, Suite 110
Bloomfield Hills, MI 48302
PHONE: (248) 335-9099
FAX: (248) 332-2404

1135 W. University Drive, Suite 425
Rochester, MI 48307
PHONE: (248) 650-5861
FAX: (248) 650-5865

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT: _____
DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____

RELEASE FROM:	**RELEASE TO:**
_____	_____
_____	_____
_____	_____

RESTRICTION: Only medical records originated through this healthcare facility will be copied unless otherwise requested.

I hereby authorize the release of information contained in my medical records, to the individuals or organizations listed above. This applies to all information in my medical record, (including information about communicable diseases and/or serious communicable diseases and/or infections as defined by Michigan statue and Department of Public Health rules, which includes Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any: psychiatric/ psychological records, if any; social work records, if any; including communications made by me to a social worker psychiatrist/ psychologist).

Reason for release of information: _____

The following information to be released (dates):

_____

____Complete Health Records	____Physical Therapy
____History/Physical	____Progress Notes
____Consults	____CT/MRI reports
____Lab reports	____X-ray reports

Other: _____

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above stated purpose and will automatically expire after 90 days from date of signature. Any disclosure of medical information is prohibited by the recipient(s) unless otherwise specified in this information.

A PHOTOCOPY WILL HAVE THE SAME AUTHORITY AS THE ORIGINAL.
The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by the federal

_____ _____
Signature of Patient Or Authorized Representative Date Signed

_____ _____
Witness Date Signed