P.O. BOX 591 CHELSEA, MI 48118
PHONE 877-210-0227 FACSIMILE 844-919-1630
E MAIL: LCRecords@thepcos.com

PATIENT ACKNOWLEDGEMENT and MEDICAL RECORDS RELEASE FORM
("Release")

OPTIONS: ***Please check ONLY one box.***

☐ 1) I wish to have my patient medical records ("Patient Records") sent to the doctor cited immediately below. I hereby authorize Seelig & Cussigh HCO, LLC to release my complete Patient Records, which includes some or all of the following personal medical information: copies of all medical exams, admission/discharge summaries, copies of lab/x-ray reports and information concerning any evaluation or treatment for psychiatric, alcohol and drug disorders. This release includes all information from the date of first treatment. Please release this information to:

____
Doctor/Medical Group

____ Suite ___________
Street Address

______________________________________ ____________________
City State Zip Doctor's Telephone Number

For Option #1 *either fax* this to (844) 919-1630 *or mail this* to the address listed above.

☐ 2) I wish to have my Patient Records sent to me. *I understand that I have reviewed with Seelig+Cussigh the content of my complete medical record and that they are releasing to the person cited below those components of the Patient Records requested by me***.**

For Option #2; please mail this completed form to Seelig & Cussigh at the address listed above.

☐ 3) I choose to have my Patient Records completely destroyed and **do not** give authorization for the release of any portion of my Patient Records.

For Option #3 *either fax* this Release to (844) 919-1630 *or mail this* to the address listed above.

This Release shall remain valid until you are notified by me, in writing, that this Release has been revoked, but in no event can this Release be revoked after June 30, 2021. In addition, to the extent that Seelig+Cussigh has released any portion, or all, of my Patient Records in accordance with my return of this Release prior to me notifying Seelig+Cussigh of a revocation of this Release, Seelig+Cussigh is not responsible for the distribution of my Patient Records.

I have been informed and advised of my right to receive a copy of this Release.
I hereby consent to the release of any and all Patient Records as described under Options 1), 2) or 3), as noted above.

I understand that a signed copy of the Release must be provided to me and affirm that, in fact, I have been provided with a copy of same.

I understand: (1) that my refusal to authorize disclosure of the Patient Records referenced herein will have no effect on my eligibility for, or receipt of, healthcare services I may either receive now or require in the future; and (2) that there is the potential that any information disclosed pursuant to this authorization could be subject to re-disclosures by the recipient without the protections/requirements of the Health Insurance Portability and Accountability Act (HIPAA), see 45 C.F.R. §164.508(b)(c), and/or California Confidentiality of Medical Information Act (California Civil Code § 56, et seq.).

REQUIRED FOR ALL OPTIONS:

____________________________ ____/____/________ ____________________________________
Patient Name – Printed Patient Date of Birth Patient (RESPONSIBLE PERSON) Signature

____ Apt. ___________
Patient's Street Address

____ __________________________________
City State Zip Patient's Telephone Number

Date: _______________________

If Executed by a person other than the Patient please provide the following:

Responsible Person's Name________________________Relation to Patient_____________________

Responsible Person's Phone Number if different from Patient: ____________________________