



# Megan Oxley, MD

1010 N. Campbell Rd., Suite 4  
Royal Oak, Michigan 48067

**Michigan Progressive Health**

Tel 248.291.7709  
Fax 248.439.0515

## Authorization to Release / Obtain Medical Records

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_

**I hereby authorize providers at Michigan Progressive Health (Megan Oxley MD, Laura Maiorana PA, Elisabeth Deller PA) to:**

**Release** Protected Health Information from my medical records to:  **Obtain** Protected Health Information from my medical records from:

Name: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults  
And neuroimaging reports. This does not include any records designated as psychotherapy notes. \_\_\_\_\_  
Dates of Service: \_\_\_\_\_

Medication records only  Labs and imaging studies only  The following specific info only: \_\_\_\_\_

### Purpose of Disclosure:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Coordination of Care   | <input type="checkbox"/> School / College  | <input type="checkbox"/> Family Member Access to Treatment            |
| <input type="checkbox"/> Consult/Second opinion | <input type="checkbox"/> FMLA / Disability | <input type="checkbox"/> Insurance application (e.g., long-term care) |
| <input type="checkbox"/> Transfer of Care       | <input type="checkbox"/> Other: _____      |   |

1. I understand that this authorization will expire one year after I have signed this form, or as specified here: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying Michigan Progressive Health or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.  
 No Substance Abuse treatment should be disclosed  No HIV/AIDS information should be disclosed

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Parent/Legal Guardian/Authorized Person \_\_\_\_\_ Date \_\_\_\_\_

### Please send to:

**Megan Oxley MD**  
**Michigan Progressive Health**  
**1010 N. Campbell Rd., Suite 4**  
**Royal Oak, MI 48067**  
**Fax: (248) 439-0515**  
**Email:**  
**droxley@michiganprogressivehealth.com**