ANDREA NOWAK, MD, PC
409 Plymouth Rd.
Plymouth, MI 48170
(734) 404-7002 Office
(734) 468-0465 Fax

NAME: _____
DATE OF BIRTH: _____

BEHAVIORAL HEALTH PROVIDER AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize the exchange of information between the
(Patient Name) (Date of Birth)
ANDREA NOWAK, MD, PC and: _____
Name

_____
Address City State Zip

_____
Telephone Number / Fax Number

To release/exchange information regarding: _____

_____

_____

_____

For the following purpose: _____

_____

_____

_____

I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider.

Requested information: _____

_____

_____

_____

_____

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

_____ _____
Signature with Credentials Date