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Traverse City, MI 49686

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ DOB: _____

Patients Phone #:_____

Requesting Records from:_____

Address:_____ Phone #:_____

To be released to: _____

Address:_____ Phone #:_____

INFORMATION TO BE RELEASED

_____ 1 year of records **(Example: Office visits, labs, EKG, special testing, etc.)**

_____ Other: _____

- **Power chart information not needed**

This information may include any of the following, unless otherwise identified:

Alcohol or drug abuse, or mental health treatment information protected under Title 42 of Code of Federal Regulations Part II.

Serious communicable and/or infectious diseases as defined by the Michigan Dept of Public Health Code 1989, Act 174, which includes venereal diseases, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) and Hepatitis.

Records and reports sent from other physicians, clinics, hospitals, or other health, medical or human service providers.

Revocation of this consent is available at any time, except to the extent that release of information has already occurred in reliance upon this consent.

The duration of this consent without express revocation is 180 days from signed date.

I authorize and request medical information be released to the name listed above.

Patient/Parent/Guardian Signature:_____

Date:_____ Witness Signature: _____