



Consent to Release Medical Information

Patient Name _____ Date of Birth _____
Address _____ Phone Number _____

I hereby Authorize: Name of Provider _____
Address _____
Phone Number _____
Fax _____

To disclose the following medical information to:
Name of Provider _____
Address _____
Phone Number _____
Fax _____

Please release the last 2 years of the following information. Also include any surgical information that is older than 2 years. (This information will **NOT** be released unless the appropriate box is initialed)

_____ Progress Notes
_____ Lab Test, Pathology Reports
_____ Cardiology Reports
_____ Other (Please Specify) _____

I understand this signed release might reveal information or medication of such information, as Alcohol and regulations and collected per 40 CFR Part 40; Psychiatric/psychological services records, social work records; information regarding serious communicable diseases and infections as defined by Michigan Department of Public Health Code (Act 368 of 1978 revised); Which includes venereal disease, tuberculosis, HTV, Aids or ARC

I also understand that there may be a fee added to the transfer of these records.

This Release is effective for six months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the above named party.

Please mark one
_____ Transferring completely out of practice
_____ Consultation Purposes
_____ Insurance Company, Attorneys
_____ Personal Use

Patient or Legal Guardian of Patient

Witness