Womens Integrated Healthcare, P.C.

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*For our Fenton, Lapeer, Clarkston, Marlette, and Sandusky offices please use the Grand Blanc office information

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Birthdate: _____

Phone#: _____ Address: _____

- I authorize _____ (office/doctor sending records) to release information contained in my chart. Including as applicable:
  - Communicable disease and infection information as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis B, HIV, AIDS, and ARC)
  - Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
  - Mental health treatment records, psychological services and social services information including communications made by me to a social worker or psychologist.

- Name of person/organization to whom disclosure is to be made (who is receiving records)

  _____

  Phone#: _____ Fax#: _____

  Address: _____

- Specific type of information to be released: _____

  _____

- Purpose/need for disclosure: _____

This consent can be revoked in writing at any time unless the Hospital has already acted in reliance upon its continued effectiveness. Without expressed written revocation, this consent expires after 180 calendar days.

Patient Signature _____ Date: _____

Parent/Guardian Signature _____

Witness _____ Date: _____