Family Medicine P.C.
29255 Northwestern Hwy. #203
Southfield, Mi 48034
Phone: 248-557-0535 Fax: 248-557-6145

Authorization For Release of Medical Information

Patient's Name: _____

Patient's Address: _____

_____
(City) (State) (Zip Code)

Social Security #: _____ Birth Date: _____

I authorize _____
to release all information contained in my patient records, including, as applicable:

- Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
- Mental Health treatment records, and psychological services and social services information including communications made by me to a social worker or psychologist.

To the individuals or organizations listed below, only under the conditions listed below:

1. Name and address of receiver of information:
   Family Medicine, P.C.,
   29255 Northwestern Hwy. #203, Southfield, Mi 48034
2. Specific type of information to be disclosed: _____
3. The purpose and need for such disclosure: _____
4. This consent may be revoked at any time unless _____ has acted in reliance upon its continued effectiveness. Regarding substance abuse treatment records, if any, this consent can last only long enough to reasonably accomplish its purpose.
5. Without expressed revocation this consent expires after 90 days or for the following specified reasons: _____

An Authorization for Release of Information Form must be completed by the patient or the personal representative. Proof must be provided if the patient is deceased, a copy of The Letter of Authority must be presented by the personal representative along with the igned Authorization. Release of records for continuation of care is limited to pertinent information only, which is sufficient for this purpose.

_____ _____
Patient's Signature Date Signed

_____ _____
Parents or Guardian's Signature Witness