AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(IMPORTANT: All blanks MUST be filled in.)

Patient Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Date of Birth: (mm/dd/yyyy) _____

Released from:

Released to:
DR. CAROLINE D. MATHEW, MD,PC
4212 Lennon Road
Flint, MI 48507
Phone: (810) 733-2311
Fax: (810) 733-8773

Specific type of information to be disclosed:

____ Any and All Records ____ Immunizations
____ Diagnostic Reports Only ____ Chart Notes Only
____ Laboratory Reports Only ____ Consultations Only
____ Other _____
FROM _____ TO _____

* Communicable disease and infection information as defined by statute and Michigan Department of Public Health rules (which includes venereal disease (VD), tuberculosis (TB), hepatitis b, human immuno deficiency virus (HIV), acquired immunodeficiency syndromes (AIDS), and AIDS related complex (ARC).

* Alcohol and drug abuse treatment information protected under 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.

The purpose and need for disclosure:

____ Transfer of Care ____ Attorney Request
____ Disability ____ Workers' Comp
____ Social Security ____ Insurance
____ Other _____

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used for disclosed as permitted under Federal and State laws (HIPPA 43# 164.502(a)).
I understand that information used or disclosed pursuant to this may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.
Without expressed written revocation, this consent expires in one year.

Signature of ___ Patient ___ Personal Representative

Printed Name

Date

If signed by Personal Representative, Relationship to Patient