Fowlerville Medical Center

Norine Tracy, M.D.
202 E. Van Riper Rd, Suite 100
Fowlerville, MI 48836
(517) 223-7900 phone
(517) 223-7635 fax

Authorization to Release Medical Information

Patient Name: _____ **DOB:** _____

Social Security No.: _____ **Phone:** _____

I,_____ , authorize the doctor/facility listed below to release information in my medical records, including as applicable: information about serious communicable disease and infections as defined by statute and Michigan Department of Public Health rules, (which includes AIDS Related Complex and HIV infection), if any; psychological service records, if any; and social service records, including communication made by me to a social worker or psychologist, if any, to the individuals or organization specified below.

Name & address of persons or organization to release records:	Name & address of persons or organization to receive records:
_____	_____
_____	_____
_____	_____
_____	_____

2. Information to be disclosed: Specify date(s) of service:
   - □ Complete Medical Record
   - □ Labs
   - □ X-rays
   - □ EKG/Cardiopulmonary
   - □ Other (Specify)_____

3. The purpose and need for the above disclosure (optional):
   - □ Continuation of care
   - □ Insurance/Billing purposes
   - □ Other (Specify)_____

This consent is subject to revocation at any time by me in writing except to the extent that action has been taken in reliance thereon, without expressed revocation, this consent expires 90 days after it is signed.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness Date