AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:____Date of Birth:____________________

Address:____

____ Phone:_________________________

Name and address of person or organization releasing information:

____

____Fax: _________________ Phone: __________________

Organization receiving information:

Northwestern Michigan Dermatology, PC
550 Munson Ave, Suite 200
Traverse City, MI 49686
(231) 935-8717 direct (231) 935-9230 fax

Information to be released:

________ Entire record
________ A specific portion of the record: From date of service ____________________ to ____________________
________ Pathology only
________ Please indicate any limitation on the information to be released:
____

*** Please mail or FAX records greater than 20 pages to 231-935-8632

This information may include any of the following unless identified immediately:

a) Alcohol or drug abuse, or mental health treatment information protected under Title 42 of the Code of Federal Regulations Part II.
b) Serious communicable and infectious diseases as defined by the Michigan Department of Community Health Code,1989, Act 174, which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and hepatitis.
c) Records and reports sent to our office or the Doctor/Doctors employed by Northwestern Michigan Dermatology PC from other **physicians, clinics, hospitals or other health, medical, human service providers.**

Purpose of release: ____

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except to the extent the release of information has already occurred in reliance upon this consent.
I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to redisclosure by the person(s) disclosure has been authorized to and that the privacy of my PHI will no longer be protected. Duration of consent, without express revocation, shall expire in 180 days from the date signed.

_______________________________ _______________________________ ____________________

Authorizing Signature | Relationship to Patient | Date Signed

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