AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I, _____, hereby authorize:
PATIENT NAME (print)

Laurel Women's Medical Group OR Other: _____
Person or organization releasing information

_____
Address

_____

its Director or designee, or Medical Information Department to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records, if any, and social work records, if any, including communications made by me to a social worker or psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or organizations listed below, only under the conditions listed below:

Patient's Phone Number ( ) _____ Patient Birthdate _____

1. Name of Person(s) or Organization(s) to whom disclosure is to be made:

NAME	PHONE (include area code)
ADDRESS	FAX (include area code)

2. Specific type of information to be disclosed:
Date From:_____ Date Through:_____

- ☐ Physician Notes
- ☐ Operative Reports
- ☐ Other: _____
- ☐ Labs
- ☐ Ultrasound/ radiology reports

3. The purpose and need for such disclosure:

- ☐ Continuation of Treatment or Health Care
- ☐ Billing Information
- ☐ Disability Determination
- ☐ Insurance Investigation
- ☐ Social Service Referral
- ☐ Other (specify)

4. Information to be ☐Mailed ☐Faxed ☐Picked up
If pickup is checked, by whom (name): _____
(If pickup by someone other than patient, include letter of authorization.) Customary copying fees and postage may be charged to the patient. .

5. This authorization is subject to written revocation at any time except to the extent that Laurel Women's Medical Group has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested information.

Signature of Patient/ Parent of a Minor/ Authorized Representative

Date