

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(Important: All blanks MUST be filled in)

Patient: _____

Address: _____

Telephone: _____

Birth date: _____

Released from:

**

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**

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Released to:

CAROLINE D MATHEW M.D.P.C

4212 Lennon Rd.

Flint, MI 48507

Phone: (810) 733 2311

Fax: (810) 733 8773

Specific Type of Information to Be disclosed: _____ Any and All records _____ Diagnostic Reports only
_____ Laboratory Results only _____ Immunizations _____ Chart Notes 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 syndrome "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 _____ Worker's Comp. _____ Social Security _____ Insurance _____ Other _____

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time by sending notification to the Privacy officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

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 or disclosed as permitted under Federal and state laws (HIPPA 45# 164.502(a)).

I understand the Practice will not condition my treatment, payment. Enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization on the requested use or disclose. Further, if the practice will receive payment for obtaining this information, I understand that I will be notified of the same.

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 representative person, Relationship to patient