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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**NOTE:** This consent cannot be honored unless COMPLETELY filled out. To ensure prompt processing, read carefully and fill in ALL appropriate spaces, including your signature and a witnessing signature.

**Patient Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Address** \_\_\_\_\_

**I hereby authorize Buchanan Family Medical Center to use or disclose the following protected health information, which may include:**

- Alcohol and drug abuse records as protected under the regulations in Title 42 of Code of the Federal Regulations, part 2.
- Any records pertaining to communicable disease or serious communicable disease and infections as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis B, HIV, AIDS, and ARC) and (specify other, if known) \_\_\_\_\_.
- Mental health records, psychological service records, social service records including communications made by me to the social worker or psychologist.
- Records pertaining to obstetrical care or family planning.

**For Date(s):** \_\_\_\_\_

**Information to be disclosed (check all desired):**

- Complete chart
- Progress notes
- Immunization record
- Lab, EKG, X-ray reports (specify) \_\_\_\_\_
- Physician/Provider completed form for \_\_\_\_\_
- Employment or school physical exam dated \_\_\_\_\_
- Information received by Buchanan Family Medical Center from \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**Purpose of disclosure:**

- Continuing care
- Personal use
- Attorney/legal
- Transferring completely out of this practice to another physician
- Other \_\_\_\_\_

**Disclose to the following party:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(continued...)

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