

Office Use Only:
 Obtain Records From: _____
 Name: _____
 Address: _____



Office Use Only:
Please fax records to:
 (269)349-0792
Or mail to:
 3304 Cooley Ct.
 Portage, MI 49024
Questions call: (269)349-2266

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient Name _____

Patient Address: _____

Patient DOB: _____

Patient SS#: _____

RELEASE TO: Name: _____

Address: _____

I, do hereby consent and authorize you to release copies of my medical records, including both current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. **I understand this Consent for Release of Medical Records will expire 1 year after the signature date.**

PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, testing, AIDS, and any AIDS-Related Syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer Results.

I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all required information as soon as possible to the address listed above:

_____ Send all my records.

_____ Send all my records: From (Date) ____/____/____ To (Date) ____/____/____.

_____ Labs: _____ Radiology: _____ Other: _____

_____ This is a permanent transfer out of our practice.

_____ I further authorize, the following person(s) may make the request for use of disclosure of my medical information (PHI) on my behalf: Myself _____ and/or Named Designee(s)

 Patient Signature

____/____/____
 Date

 Witness Signature

____/____/____
 Date