

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.

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