WOMEN'S INTEGRATED HEALTHCARE, P.C.

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FAX 810-606-9400

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(810) 653-0388.
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(248) 922-0615
FAX 248-922-9162

17200 Silver Parkway
Fenton, MI 48430
(810) 714-5361
FAX 810-714-9661

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Birthdate: _____

Patient's Address: _____

Social Security # _____ Telephone #: _____

Maiden/Other Names: _____

I authorize _____ to release information contained in my patient records, including as applicable:

- Communicable disease and infection information as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC") and (specify other, if known) _

  _____

- Alcohol and/or drug abuse treatment information protected under the 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.

1. Name and address of person or organization to whom disclosure is to be made: _____
   _____
   _____

2. Specific type of information to be disclosed (include dates and type of treatment): _____
   _____
   _____

3. The purpose and need for disclosure: _____
   _____

This consent can be revoked in writing at any time unless the Hospital has already acted in reliance upon its continued effectiveness.

Without expressed written revocation, this consent expires after 180 calendar days.

Witness _____ Patient's Signature _____

_____
(and Parent/Guardian Signature where appropriate)

_____ _____