WOMEN'S INTEGRATED HEALTHCARE, P.C.

1595 Genesys Parkway
Grand Blanc, MI 48439-8068
(810) 606-9190
FAX 810-606-9400

10004 Lippincott, Suite 3
Davison, MI 48423
(810) 653-0388.
FAX 810-653-0929

5900 Waldon Road, Suite D
Clarkston, MI 48346
(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

'atient's Name: _____ Birthdate: _____

'atient's Address: _____

ocial Security # _____ Telephone #: _____

Maiden/Other Names: _____

authorize _____ to release information contained in my patient records, ncluding 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.

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

_____

_____

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

_____

_____

. The purpose and need for disclosure: _____

_____

his consent can be revoked in writing at any time unless the Hospital has already acted in reliance upon its con- nued effectiveness.

/ithout expressed written revocation, this consent expires after 180 calendar days.

/itness _____ Patient's Signature _____

_____

(and Parent/Guardian Signature where appropriate)

_____ _____

Date