Authorization for Release of Information

Records Needed By: ______________________

Patient: ______________________ DOB: ____/____/____ ID #: ____________

Mailing Address: ______________________

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Home Phone #: ______________________ Cell Phone #: ______________________

Dates Covered: ☐ All ☐ Last 2 years ☐ Specific Dates—From ____________ to ____________

Please check all that apply:

I hereby authorize the release of my medical information, including (if any):

- ☐ Alcohol and drug abuse records protected under the regulation in 42 Code of Federal Regular Part II
- ☐ Psychiatric/Psychological service records and social work records
- ☐ Information regarding serious communicable diseases and infections as defined by the MDPH code (Act 368 of 1978 as revised), which included venereal disease, TB, HIV, AIDS or ARC

My information may be released FROM the organization listed below:

☐ ______________________

☐ ______________________

My information may be released TO the organization listed below:

☐ Great Lakes Ear, Nose & Throat Specialists

☐ ______________________

Specific type of information to be disclosed:

☐ All information related to my care ☐ ______________________

The purpose and need for such disclosure is:

☐ Continuation of treatment or health care follow-up

This authorization is subject to written revocation at any time to the extent that Great Lakes Ear, Nose and Throat Specialists has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate in six months from the date of signature.

______________________ ____________

Signature of Patient or Authorized Representative Date

______________________ ____________

Signature of Witness Date