DERMATOLOGY ASSOCIATES
OF NORTHERN MICHIGAN, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Phone Number: _____

I, _____ hereby authorize the release of my medical information to:
Patient's name (please print)

DERMATOLOGY ASSOCIATES OF NORTHERN MICHIGAN, P.C.
4170 Cedar Bluff Drive
Petoskey, MI 49770
Phone: (231) 487-2230 Fax: (231) 487-6172

Charge: Yes $.
No $ XXX.XX

Patients are allowed one (1) copy of their medical records at no charge. Additional copies are subject to copying fees.

Including (if any):

- Alcohol and drug abuse records protected under the regulation in 42 Code of Federal Regulation, Part 2,
- Psychiatric/physiological services records, social work records,
- Any information regarding serious communicable diseases and infections as defined by Michigan Department of Public Health Code (Act 368, of 1978 as revised), which includes venereal disease, tuberculosis, HIV, AIDS, or ARC.

MY INFORMATION MAY BE RELEASED TO THE INDIVIDUALS OR ORGANIZATIONS LISTED BELOW, ONLY UNDER THE CONDITIONS LISTED BELOW:

1. Name of person(s) or organization(s) to whom the information is to be released to and dates of service:

Person/Agency Receiving Information:	
Address City, State, Zip Code	
Phone Number:	

2. Specific type of information to be disclosed (please check) and dates of service:

	Any information related to my care for:	
	Progress Notes	
	History & Physical	
	Pathology/Lab Reports	

3. The purpose and need for such disclosure: (please check)

	Continuation of treatment or health care, follow up
	Lawyer/Legal
	Billing information/Insurance investigation
	Social Service Referral
	Disability Determination
	Workers Compensation
	Other (specify):

4. This authorization is subject to written revocation at any to the extent Dermatology Associates of Northern Michigan P.C. has already taken action in reliance on the authorization. If not previously revoked, this authorization expires six (6) months from the date of signature.

Signature of Patient/Authorized Legal Representative: _____ Date: _____

Signature of Legal Guardian of Minor: _____ Date: _____

Signature of Witness: _____ Date: _____