AOC Arthritis & Osteoporosis Center

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of Birth ___/___/___

I authorize and request that any and all medical information be released under the following conditions:

1. Name and address of persons or organizations releasing information:

2. Name and address of persons or organizations receiving information:

3. Purpose or need to release information: Continuation of Care

4. Information to be released:

5. Information may include any of the following, unless identified immediately above see (4):

   a. Alcohol or drug abuse, or mental health treatment information protected under Title 42 of the Code of Federal Regulations Part II.
   b. Serious communicable and infectious diseases as defined by the Michigan Department of Community Health Code, 1989, Act 174, which includes Venereal Diseases, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and Hepatitis.
   c. Records and reports sent to: _____
   or Dr./Drs.: _____

6. Revocation of Consent: This consent is subject to revocation at any time, except to the extent that release of information had already occurred in reliance upon this request.

7. Duration of Consent: Without express revocation, this consent shall expire at one year from date signed.

_____ _____
Signature of Person Giving Consent Witness

___/___/___ _____
Date Relationship to Patient

Revised 03/02/2006