AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____Date of Birth:____/_____/_____

Address_____SS#_____/_____/_____

_____ Phone #_____

Maiden or Other Name_____

I authorize_____ Phone#_____

Address _____

To release all medical information contained in my patient records.

To: Malgorzata Sobilo, M.D. Phone# 248-693-6238
720 N. Lapeer Rd., Suite 102 Fax# 248-693-7649
Lake Orion, MI 48362

This consent can be revoked at any time. All information received is protected under Federal Law. Without expressed revocation this consent expires 60 days or for following specific reasons, whichever is later.
Information about communicable disease and serious communicable disease and infection, as defined by stature and Michigan Department of Public Health Rules (that include venereal diseases, tuberculosis, hepatitis B, immunodeficiency virus, immunodeficiency syndrome, or AIDS related complex) and other, specify if known.
Alcohol and drug abuse treatment information protected under the (42 Code of Federal Regulations, Part 2)
Mental health treatment records, psychological services, social services information including communication made to me to a social worker or psychologist only as specified below.

The purpose and need for such disclosure_____

Specific type of information to be disclosed_____

_____ _____
Patient Signature Witness

_____ _____/_____/_____
Parent or Guardian Signature Date

_____/_____/_____
Date