NORTH OAKLAND INTERNISTS, P.C.
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

RELEASE FROM:	RELEASE TO:
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize the release of information contained in my medical records, to the individuals or organizations listed above. This applies to all information in my medical record, (including information about communicable diseases and/or serious communicable diseases and/or infections as defined by Michigan statute and Department of Public Health rules, which include Human immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, if any: alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal Regulations Part 2, if any: psychiatric/ psychological records, if any; social work records, if any; including communications made by me to a social worker psychiatrist/psychologist)

Reason for release of information:_____

The following information to be released (dates):_____

___ Complete Health Records	___ Lab reports
___ Face Sheet	___ Xray reports
___ ER Records	___ Cardiology reports
___ History/Physical	___ Operative / Path reports
___ Summary	___ Progress Notes
___ Consults	___ Medication / IV records

Other_____

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above stated purpose and will automatically expire after 90 days from date of signature. Any disclosure of medical information is prohibited by the recipient(s) unless otherwise specified in this authorization.
A PHOTOCOPY WILL HAVE THE SAME AUTHORITY AS THE ORIGINAL.

_____ _____ _____
Signature of Patient / Parent of a minor Or Authorized Representative — Relationship — Date Signed

_____ _____
Witness — Date Signed

11/98 corresp.