DOVETAIL Family Practice
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HEALTH INFORMATION RELEASE AUTHORIZATION

I, _____ _____
(Print Patient's Name) (Telephone Number)

_____
(Address)

authorize _____
(Name of Facility releasing medical information)

_____
(Address)

to release information contained in my patient records, including, as applicable: information about communicable diseases and serious communicable diseases and infections, as defined by statue and Michigan Department of Consumer & Industry Services (MDCIS) (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndrome"AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulations, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. Name and address of receiver of information:

_____

_____

2. Specific type of information to be disclosed, (include date(s) of service):

_____

_____

3. The purpose and need for such disclosure:

_____

_____

I represent that I am the patient or an Authorized Representative of the patient as that term is defined in Michigan law regarding the release of medical records.

***** _____ _____
Signature of Patient or Authorized Representative **Date**

_____ _____
If signed by Authorized Representative, relationship to patient **Signature of Witness**

_____ Last 4 digits of Patient's Social Security Number **(***-**-_____)**
Patient's Date of Birth