AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ______________________________, hereby authorize the release of my medical information from **Doctor Linehan/Northern Michigan Allergy & Asthma Center** to:

Physician/Facility Name:____
Address: ____
City, State, Zip: ____
Phone: ____

Information from the medical record of:
Patient Name: ____
Address: ____
Birth Date and or Social Security Number: ____
Phone: ____

Including (if any):

* alcohol and drug abuse records protected under the regulation in 42 Code of Federal Regulation, Part 2.
* psychiatric/psychological service 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 ABOVE, ONLY UNDER THE CONDITIONS LISTED BELOW:

__________ Continuation of treatment or health care
__________ Legal
__________ Billing information/insurance investigation
__________ Disability determination
__________ Other (specify): ____________________
__________ Decline disclosure reason

The Physician, Facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

This authorization will terminate six (6) months from date of signature.
Signature of Patient/ ____ Date: ________________
Authorized Representative:

Relationship to Patient (if applicable) ____________________________________

Signature of Witness ____ Date: _______________

APPLICABLE COPY FEES UNDER MMRA MUST BE PAID PRIOR TO RELEASE OF RECORDS. ALL RECORDS WILL BE MAILED. WE ARE UNABLE TO FAX RECORDS.
COPY/POSTAGE FEE: _______________ **PAID:** __________________

NOTICE TO RECIPIENT:
The recipient of the enclosed information is not authorized to use this patient's medical records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.