Authorization for Release of Information

Records needed by: ____________________

Patient: _____________________________ Birth Date: ____/____/_______ ID #:_________
Mailing Address: ____
____
____

Home Phone #: ________________________ Cell Phone #: ______________________________

Dates Covered: ☐ All ☐ Last 2 years ☐ Specific Dates- From ________to __________

Please check all that apply:

I hereby authorize the release of my medical information including (if any):

☐ Alcohol and drug abuse records protected under the regulation in 42 code pf Federal Regular Part II

☐ Psychiatric/Psychological service records and social word records

☐ Information regarding serious communicable disease and infections as defined by the MDPH code (Act 368 of 1978 as revised), which included venereal disease, TB, HIV, AIDS, or ARC.

My information may be released FROM the organization listed below:

☐____

☐____

My information may be released TO the organization listed below:

☐ Great Lakes Ear, Nose & Throat Specialists

☐ ____

Specific type of information to be disclosed:

☐ All information related to my care ☐ ____

The purpose and need for such disclosure is:

☐ Continuation of treatment or health care follow up

This authorization is subject to written revocation at any time to the extent that Great Lakes Ear, Nose and Throat Specialists has already taken action in reliance on the authorization. If not previously revoked, this authorization will terminate in six months from the date of signature.

____ ____________________
Signature of Patient or Authorized Representative Date

____ ____________________
Signature of Witness Date

Phone: (231) 489-8151 Fax: (231) 668- 7794

1114 Charlevoix Ave., Petoskey, MI 49770 · 860 N. Center Ave., Gaylord, MI 49735 · 101 Oxbow Dr., Alpena, MI 49707
P: (231) 489-8151 · F: (231) 668-7794 · GreatLakesENT.com