MID-MICHIGAN PODIATRY, PC

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AUTORIZATION FOR RELEASE OF MEDICAL INFORMATION BY PATIENT

Patient Name________________________________ Date of Birth________________

I authorize and request the described information be released under the following conditions:

1) Name of Persons or organizations to disclose information:

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2) Name of persons or organizations to whom disclosure is to be made:

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3) The purpose or need for such disclosure:

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4) Extent or nature of information to be disclosed:

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5) Information may include any of the following
   a) Alcohol or drug abuse, or mental health treatment information protected under Title 42 of the Code of Federal Regulation Part II
   b) Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174.which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS Related Complex (ARC) and hepatitis.

6) Revocation of Consent: This consent is subject to revocation at any time except to the extend that action has been taken in reliance upon this consent.
7) Duration of consent: Without expressed revocation, this consent expires in 180 days.
8) If you have HIV testing, do you want this information released as part of your medical record? Yes No

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Signature of Patient or Legal Guardian Date

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Witness Date