MEDICAL CLINIC OF NORTHVILLE

308 South Main Street
Northville, MI 48167
(248) 349-1900
Fax (248) 349-3195

AUTHORIZATION FOR MEDICAL RECORD RELEASE

I, _____ authorize the doctor or medical office listed below to release **my** medical records, including as applicable, information about communicable diseases and serious diseases and infections, as defined by statute and Michigan Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and Aids related complex "ARC"), alcohol and drug abuse treatment information protected under the Federal Regulations, Part 2, Code 42, psychological services and social services information including communications made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. **Patient Information**
   Name: _____
   Address: _____
   City/State/Zip: _____
   Telephone Number: _____
   Date of Birth: _____
   Social Security Number: _____

2. **Doctor Releasing Info**
   Name: **Medical Clinic of Northville**
   Address: **308 S. Main Street**
   City/State/Zip: **Northville, MI 48167**

3. **Receiver Information**
   Name: _____
   Address: _____
   City/State/Zip: _____

4. Is disclosure to an attorney? ( )Yes ( )No Is he/she the patient's own attorney? ( )Yes ( )No

5. Specific type of information to be disclosed: _____
   _____

6. The purpose and need for such disclosure: _____
   _____

7. This consent is subject to revocation at any time except in those circumstances in which the Clinic has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, consent given with respect to alcohol and/or drug abuse records shall have a duration no longer than reasonably necessary to effectuate the purpose for which it was given.

_____ _____
Patient Signature (Parent/Guardian where applicable) Date

_____ _____
Witness Signature Date