**AUTHORIZATION FOR**
**DISCLOSURE OF PATIENT MEDICAL INFORMATION**

| | |
|---|---|
| Last Name: | First name: |
| Date of Birth: | Phone number: (  ) |

I hereby authorize:

Company:_____
Address:_____
Phone:_____
Fax:_____

Its Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records, and if, any social work records, if any, including communications made by me to a social worker or psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS or ARC, if any, to:

Michigan Vascular Access
21701 West Eleven Mile Rd, Ste 4
Southfield, MI 48076
(248) 355-1100
Fax (248) 355-2361

St. Mary's Mercy Medical Group
36475 Five Mile Rd
Livonia, MI 48154
(734) 655-2109
Fax (734) 655-2942

And only for the conditions listed: Continuation of treatment or health care.
The type of information to be disclosed:
Date:_____ Date through:_____

- ❑ Discharge Summary
- ❑ Cardiology: 2D echos; Stress testing; Catherizations; consultations
- ❑ Completed, recent History and Physical
- ❑ Other:_____

Please **FAX** the requested information **AS SOON AS POSSIBLE**.

This authorization is subject to written revocation at any time except to the extent that the above provider has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested information or _____.

_____Date:_____
**Signature** of Patient/Parent of minor/Authorized Representation

***URGENT: ATTENTION***