

Rochester Endocrinology & Diabetes Center
135 Barclay Circle, Suite 104, Rochester Hills, MI 48307
Phone: (248) 853-7270 * Fax: (248) 853-7230

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

I, _____, hereby authorize _____, its Director or designee, or Medical Record Department, to release information contained in my patient records, to the individuals or organizations listed below, only under the conditions listed below. This applies to all information in my medical record, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any, and social service records, if any, including communications made by me to a social worker or psychologist; and infection as defined by statute of Michigan Department of Public Health rules which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", AIDS related complex "ARC" and _____ (specifically any other communicable disease, if known).

INFORMATION TO BE RELEASED TO:

Name: Smita Bijlani, MD
Name: Reshma Ramakrishnan, MD

Address: 135 Barclay Circle, Suite 104

City: Rochester Hills

State & Zip: Michigan 48307

INFORMATION TO BE RELEASED FROM:

Name: _____

Address: _____

City: _____

State & Zip: _____

The following information is to be released:

Laboratory Test Results Radiology Reports Office Visit Notes
 Complete Health Records Others (please specify): _____

REASON FOR RELEASE OF INFORMATION: _____

I understand I can revoke this release at any time except in those circumstances where the corporation has taken certain actions of the understanding that my consent will continue unrevoked until the purpose for which I have given the consent has been accomplished. However, any consent I have given with respect to alcohol and/or drug abuse records will not last any longer than what is reasonably necessary to accomplish the purpose of this release, as I have explained it above. Without my expressed revocation, this consent expires six (6) months from the date below.

Signature of Patient/Guardian

Date

Signature of Witness

Date