Eastman & Vempati, MD, PC

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Please Do Not Fax Entire Charts to our Office

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_________________________________ Birth Date________________________

Patient Address_______________________________ Soc. Security #____________________

Telephone #______________________ Other Names: _______________________________

I authorize ________________________________, phone # ____________________, fax

#___________________, to release all information contained in my patient records, including as applicable:

- Information about communicable disease and serious communicable diseases and infections as defined by statue and 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 (specify other, if known).
- Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker or psychologist only as specified below:

1. Name and address of receiver of information: _______________________________________

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2. Specific type of information to be disclosed: _______________________________________

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3. The purpose and need for such disclosure: ____

   ____

   (if the records are mental health records, how is the release of them relevant to this purpose?)

4. This consent can be revoked at any time unless this physician network has acted in reliance upon its continued effectiveness. Regarding substance abuse treatment records, if any, this consent can last only long enough to reasonably accomplish its purpose.

5. Without expressed revocation this consent expires after 60 days or for the following specific reasons, whichever is later: ____

6. There will be a reasonable and customary fee charged for copying and/or transferring medical records from this office. **($25)**

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Signature of Patient/Parent Date