Doctor's Approach Dermatology
Marcy L. Street, MD
2685 W. Jolly Road, Okemos, MI 48864
(517) 993-5900 Fax (517) 332-1696

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____Date of Birth: _________________

I hereby authorize and request you to release to Doctor: ______________________________________
Address: ____
Phone Number: ______________________________ Fax Number: ______________________________

From: Doctor: ____
Address: ____
Phone Number: ______________________________ Fax Number: ______________________________

(Please initial appropriate box)

________ Entire Health Record
________ Specific Dates of Treatments: From: _____________________ To: ______________________
________ Other____

This release also specifically allows the release of the following information (this information will not be release unless the appropriate box is initialed):

______ Any record of treatment for Drug and/or Alcohol dependency or abuse;

______ Any record of Mental Health treatment;

______ Any record if testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases

This information is being released for the following purpose (s) only: _____________________and may not be used for any other purpose or released to any other person (s) without my written consent.

This release is effective for six months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the above name party.

____ ________________________________
Signature of Patient or Legal Guardian Date

____
Witness