AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

KENTWOOD
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wmifamilymed.com

1.) ______________________________ ______________
Patient Name Birth Date

____
Street

____
City / State / Zip

____
Telephone Social Security Number

2.) I Authorize:

____

____

____

to release my information to:

WEST MICHIGAN FAMILY MEDICINE, PC
2120 43rd St SE, Suite 200
Kentwood, MI 49508

3.) The information to be released is: (choose one)

☐ ALL records

I understand this is my expressed consent to release ALL health care information, including:

- Alcohol and/or drug abuse and mental health information
- Serious communicable and infectious disease, including but not limited to: venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and hepatitis.
- Information relating to pregnancy and birth control.
- Information received from other physicians

☐ I am specifically authorizing the release of ALL health care history, examination, testing and treatment information as described above **except**:

____

☐ Other: ______________________________

4.) Reason for Release:______________________________

5.) ______________________________
Signature of patient or legal representative

This authorization will expire 90 days after the date of the signature______________(Exp. Date)

It is understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. It is also understood that this authorization may be revoked in writing at any time, except to the extent that we have already taken action in reliance of your authorization.