East Bay Medical Center, P.C.
1401 Short Drive P.O. Box 19 Prudenville, MI 48651
(989) 366-1515 Fax: (989) 366-1501

Patient Information

For :

Consent for Release of Information

Med. Rec. #:

I_____
(Please print the name of the person completing this form)

Authorize:_____
(Please print the name of clinic, hospital or individual)

to disclose the following medical treatment information

to:_____
(Please print the name of clinic, hospital or individual)

for care provided to: fake fake

on these dates:_____

The information released will be used for the following purpose:

_____

I specifically authorize the release of the following:

___Entire record ___Only those items listed below:

___Drug/Alcohol Abuse Treatment
___Psychiatric and Mental Illness Treatment
___Human Immunodeficiency Virus (H.I.V.) Antibody Test, Results, and Treatment Information
___Registration Record
___History and Physical
___Operative Report
___X-Ray Report
___EKG Report
___Lab Report
___Visit/Encounter Notes
___Other-Specifically:_____

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 90 days from the date signed, unless otherwise specified as follows:_____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

_____
Signature of Patient/Date

_____
SSN, Date of Birth, and Other Names Used

_____