AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(IMPORTANT: ALL BLANKS MUST BE FILLED IN)

Patient: _____

Address: _____

Telephone: _____ Birth date: _____

Released From:

_____

_____

_____

_____

Released To:

Dr. Randolph Schumacher MD
1409 S. Graham Rd
Flint MI 48532
(810)235-2599

Specific type of information to be disclosed: _____ Any and All Records _____ Diagnostic Reports Only _____ Laboratory Results Only _____ Immunizations _____ Chart Notes Only _____ Consultation Notes Only _____ Other _____ Time Period: _____

*Communicable disease and infection information as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").
*Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.
*Mental health treatment records, psychological services and social services information, including communications made be me to a social worker or psychologist.

The Purpose and need for disclosure: _____Transfer of Care _____Attorney Request _____ Disability _____ Workers' Comp _____ Social Security _____ Insurance _____ Other: _____

I release the above physician(s) and HCT from all responsibility or liability that may arise from the release of this information or these records.

I understand, as set forth in the practice's Notice of Privacy Practices. I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws and that this request may be processed via Healthcare Technologies of Mid-Michigan, Inc. (copy service).

I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Without expressed written revocation, this consent expires after one year.

_____ _____

Signature of: ____ Patient ____ Personal Representative

Printed Name

Dated: _____

_____

If Personal Representative-Relation to Patient