PRIMECARE OF NOVI

39555 WEST TEN MILE ROAD
SUITE 302
NOVI, MI 48375
(248) 426-7200
FAX: (248) 426-7335
"MODERN MEDICINE; OLD-FASHIONED CARE"

AUTHORIZATION TO DISCLOSE PATIENT MEDICAL INFORMATION

DATE: _____
ORGANIZATION RELEASING INFORMATION:

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

ORGANIZATION TO WHOM DISCLOSURE IS TO BE MADE:

NAME: **PRIMECARE OF NOVI**
ADDRESS: **39555 WEST TEN MILE RD STE 302 NOVI,MI 48375**
PHONE & FAX NUMBER: **PH# 248-426-7200 FAX# F248-426-7335**

I HEREBY AUTHORIZE YOU OR YOUR ORGANIZATION TO RELEASE ALL INFORMATION CONTAINED IN MY RECORDS, INCLUDING AS APPLICABLE:

- INFORMATION ABOUT HUMAN IMMUNODEFICIENCY VIRUS (HIV), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC).
- ALCOHOL AND DRUG ABUSE INFORMATION PROTECTED UNDER THE REGULATION IN CODE 42 OF FEDERAL REGULATIONS, PART 2 AND
- MENTAL HEALTH TREATMENT RECORDS, AND PSYCHOLOGICAL SERVICES AND SOCIAL SERVICES INFORMATION INCLUDING COMMUNICATIONS MADE BY ME TO A SOCIAL WORKER OR PSYCHOLOGIST.

PATIENT NAME (PRINT)_____
PATIENT ADDRESS:
_____
_____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:**_____

1. Specified type of information to be disclosed: _____ All Records **or** as specified below: _____
   _____

2. **Dates of treatment:** _____ All **or** as specified: _____

3. The purpose and need for such disclosure: _____ Continuation of Care **or** as specified below: _____

4. This consent can be revoked at any time unless PrimeCare of Novi 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.

SIGNATURE OF PATIENT: _____

Parent of Guardian where appropriate: _____

Witnessed By: _____ **Date Signed:** _____