PRIMECARE OF NOVI

39555 WEST TEN MILE ROAD
SUITE 302
NOVI, MI 48375
(248) 426-7200
(248) 426-7335 (FAX)

AUTHORIZATION TO DISCLOSE PATIENT MEDICAL INFORMATION

DATE: _____

ORGANIZATION RELEASING INFORMATION:

NAME: **PRIMECARE OF NOVI**

ADDRESS: **39555 W TEN MILE STE 302 NOVI, MI 48375**

PHONE NUMBER: **PH# 248-426-7200 FAX # 248-426-7335**

ORGANIZATION TO WHOM DISCLOSURE IS TO BE MADE:

NAME: _____

ADDRESS: _____

PHONE & FAX NUMBER: _____

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 #**: _____

SPECIFIED TYPE OF INFORMATION TO BE DISCLOSED: _____ **ALL RECORDS OR** AS SPECIFIED BELOW DATES OF TREATMENT:

_____

_____

1. THE PURPOSE AND NEED FOR SUCH DISCLOSURE: _____ **CONTINUATION OF CARE OR AS SPECIFIED BELOW**: _____
2. 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: _____