Endocrine & Metabolic Disorders
2177 Auburn Road, Shelby Twp Mi48317
*Phone: (586) 737-7520 * Fax: (586) 737-7591*

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name:_____ Date of Birth:_____

Address: _____ State: _____ Zip: _____

I, _____, hereby authorize _____, its Director or designee, or Medical Record Department, to release information contained in my patient records, to the individuals or organizations listed below, only under the conditions listed below. This applies to all information in my medical record, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any, and social service records, if any, including communications made by me to a social worker or psychologist; and infection as defined by statue of Michigan Department of Public Health rules which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", AIDS related complex "ARC" and _____ (specifically any other communicable disease, if known).

INFORMATION TO BE RELEASED TO:	INFORMATION TO BE RELEASED FROM:
Name: Ashish Verma, MD	Name: _____
Address: 2177 Auburn Road	Address: _____
City: Shelby Twp	City: _____
State & Zip: Michigan 48317	State & Zip: _____

The following information is to be released:

___ Laboratory Test Results ___ Radiology Reports ___ Office Visit Notes
___ Complete Health Records ___ Others (please specify): _____

REASON FOR RELEASE OF INFORMATION: _____

Fee For Medical Records: Initial fee $23.62 pages 1-20 $1.18 per page
Pages 21-50 $0.59 per page

I understand I can revoke this release at any time except in those circumstances where the corporation has taken certain actions of the understanding that my consent will continue unrevoked until the purpose for which I have given the consent has been accomplished. However, any consent I have given with respect to alcohol and/or drug abuse records will not last any longer than what is reasonably necessary to accomplish the purpose of this release, as I have explained it above. Without my expressed revocation, this consent expires six (6) months from the date below.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Witness Date