RELEASE OF INFORMATION

Authorization for Disclosure of Protected Health Information/Records Release Including Confidential and Restricted Confidential Information

Name:			**Home Phone:**			
DOB:			**Cell Phone:**			
Address:						
			Email:			

I authorize and request the described information to be disclosed under the following conditions:

1. Name of person(s) or organization(s) to disclose information: **Robyn D. Messing, D.O., PLLC**

2. Name of organization to receive information: **Family Medicine of Michigan**

3. The purpose or need for such disclosure: Robyn D. Messing, D.O,, PLLC has my permission to release my protected health information (PHI) to the above named organization for continuation of care.

4. I **do not** wish any of the following "Restricted Confidential" information to be disclosed. I understand that by leaving the boxes below unchecked I am giving you additional specific consent to disclose Restricted Confidential information that you may be in possession of.
   - ❑ Alcohol or drug abuse, or mental health information under Title 42 of the Code of Federal Regulation Part II.
   - ❑ Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174 which includes venereal disease, tuberculosis, HIV, AIDS, AIDS related complex and Hepatitis.
   - ❑ Records and reports you may have from other health care providers including hospitals and physicians.

5. Revocation of Consent: This consent is subject to revocation at any time except to the extent action has been taken in reliance upon this consent. Any revocation of consent must be in writing.

6. This authorization is valid for **your lifetime** unless an alternative expiration date is provided here:

_____.

_____ Date_____

Signature (or Legal Guardian)

_____

Printed Name (or Legal Guardian)

_____ Date _____

Witness **Signature**

_____

Witness **Printed Name**