



**AUTHORIZATION FOR RELEASE
OF MEDICAL RECORD INFORMATION**

1015 S. Washington
Saginaw, MI 48601
Phone: (989) 754-3000
Fax: (989) 754-3002

301 W. Wackerly Road
Midland, MI 48640
Phone: (989) 832-0900
Fax: (989) 633-0349

3720 Katalin Court, Suite 100
Bay City, MI 48706
Phone: (989) 671-2700
Fax: (989) 671-2701

Patient _____
Last First Middle Date of Birth

Address _____ (_____) _____
Street City State Zip Code Telephone Number

I hereby authorize _____
to furnish the most current year's documentation of medical treatment to _____

Additional documentation requested:

- | | | |
|--|---|---|
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> EP Studies | <input type="checkbox"/> Holter |
| <input type="checkbox"/> Angioplasty/Atherectomy | <input type="checkbox"/> Stress/Nuclear | <input type="checkbox"/> Echocardiogram |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Operative Report | |
| <input type="checkbox"/> Other _____ | | |

THE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE

- INSURANCE PAYMENT OR CLAIM LEGAL MATTER CONTINUED MEDICAL CARE
- OTHER _____

I hereby release MCVI from all responsibility or liability that may arise from the release or receipt of this information or these records. I authorize and request MCVI to release or obtain (as the case may be) information contained in my patient records, including as applicable: Alcohol and drug abuse and mental health treatment information protected under the regulation in Title 42 of the Code of Federal Regulations Part II, information about communicable diseases, and serious communicable diseases and infections, as defined by Department of Public Health rules (Michigan Public Health Code) which includes venereal diseases, tuberculosis, human immunodeficiency virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS-related complex - ARC.

This authorization will expire one hundred eighty (180) days after the date below.

I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken by my authorization. Such revocation must be in writing and sent to MCVI Medical Records Dept.

SIGNATURE OF PATIENT		DATE SIGNED
X		
AUTHORIZED PERSONAL REPRESENTATIVE	DATE SIGNED	For office use only
X		Personal Representative Verified _____
SIGNATURE OF WITNESS		Copy of Verification attached _____
X		