

SUSAN LITTLE-JONES, M.D., P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_, its Director or designee, or Medical Records 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. It also includes psychological services records, if any, and social service records, communication made by me to a social worker or psychologist, and infectious diseases as defined by statute and 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 (specify any other communicable diseases, if known).

Information to be released FROM:

Susan Little-Jones, M.D., P.C.

Susan Little-Jones, M.D.

Phone #: 248-844-0315

35200 Dequindre Rd., Suite 600

Fax #: 248-844-0320

Sterling Heights, MI 48310

Information to be released TO:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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The following information is to be released:

Complete Health Records \_\_\_\_\_ Lab Test Results \_\_\_\_\_ Others \_\_\_\_\_

REASON FOR RELEASE OF INFORMATION: \_\_\_\_\_

I understand I can revoke this release at any time in those circumstances where the corporation has taken certain actions on 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.

\_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient/Guardian

Signature of Witness

Faxed/Mailed: \_\_\_\_\_

By: \_\_\_\_\_