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 statue 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 TO:

Susan Little-Jones, M.D., P.C.
Phone #: 248-844-0315
Fax #: 248-844-0320

Susan Little-Jones, M.D.
35200 Dequindre Rd., Suite 600
Sterling Heights, MI 48310

Information to be released FROM:

Name: ____

Address: ____

City: ___________________________ State: ________________ Zip: ______________________

Phone #: ______________________________ Fax #: ____

****

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 thatmy 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 that 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: ________________