ARBOR MEDICAL
PARTNERS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

_____
Doctor/Medical Facility/Parent

_____
Address

_____
City/ State/ Zip Code

_____
Phone/ Fax

_____ Release records **TO** Arbor Medical Partners
_____ Release records **FROM** Arbor Medical Partners

I authorize the following types of information to be released:

___ Complete Records
___ Imaging Results
___ Lab Results
___ Immunizations
___ Office/Clinical Notes
___ Growth Charts
___ Medications
___ Other: _____

Specific authorization for release of information protected by State or Federal Law. I specifically authorize for the release of information relating to:

___ Mental Health
___ Substance Abuse
___ HIV related
___ Developmental Disability Records

Purpose for Release:

___ Moving out of State
___ Switching Clinics
___ Legal
___ Education
___ Other: _____

Receive records via:

___ Email: _____
___ Fax: _____
___ Mailed to the above address

I authorize you to furnish a copy or summary of medical records on the listed child/children to the listed Doctor/Medical Facility/Person. I release you from all legal responsibility of liability that may be derived from this authorization.

_____ _____
Patient/Parent/Legal Guardian Printed Name Relation to Patient

_____ _____
Patient/Parent/Legal Guardian Signature Date

****This form expires 1 year from date signed****