MOUNT PLEASANT MEDICAL ASSOCIATES

4639 E Pickard St., Suite B
Mt. Pleasant, Michigan 48858

Authorization for Release of Health Information

(Release to another Health Care Provider **Only)**

Patient Name _____ Birth date _____ Social Security Number _____

Address _____

Telephone Number _____

I authorize _____ to disclose the above named individual's
Name of Physician, or Organization and Phone Number

health information as described below to Dr Nisha Vashishta 4639 E. Pickard St, Suite B, Mt. Pleasant, MI 48858; Fax # 989-817-4301, Mount Pleasant Medical Associates

Specific type of information to be disclosed: Date(s) of Service: _____ Type of Service: _____

☐ History and physical ☐ Physician's Notes ☐ Consultation reports ☐ Entire Medical Record
☐ Nurse's Notes ☐ Laboratory results from (date)_____ to (date)_____
☐ Diagnostic Imaging (X-Rays) reports from (date) _____ to (date) _____
☐ EKG & interpretations from (date) _____ to (date) _____
☐ Other _____

The purpose and need for disclosure:

☐ Continuation of Care ☐ Disability Determination ☐ Vocational Rehabilitation
☐ Social Service Referral ☐ Insurance Billing ☐ Legal Follow-Up
☐ Comparison Studies ☐ Other _____

I understand that any information in my records relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse may be disclosed.

I understand that any disclosure of information carries with it the potential for redisclosure.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to:

_____.
Name of Individual, Entity, or Organization

I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

X _____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, State Relationship to Patient

_____ _____
Signature of Witness Date