ROCHESTER INTERNISTS, PLLC

AUTHORIZATION FOR RELEASE AND CONSENT FOR DISCLOSURE
OR REQUEST FOR MEDICAL INFORMATION

Rochester Internists, PLLC, 2708 S. Rochester Rd., ste A, Rochester Hills, MI 48307
Phone:(248)844-1500, Fax: (248)844-1501

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*I,*_____, *authorize*
(Patient name/ print name)

_____**Request** only medical Information or medical record-diagnosis, admission summary, discharge summary, and/or psychological testing.
_____**Release** all pertinent written and verbal information **to** individuals or organizations listed below.

Name/Office_____ **Address**_____

Phone Number:_____ **Fax:**_____

Name/Office_____ **Address**_____

Phone Number:_____ **Fax:**_____

Name/Office_____ **Address**_____

Phone Number:_____ **Fax:**_____

Specific information **released/requested** includes:

____ Progress Notes ____ Lab and Pathology Reports

____ Diagnostic Reports ____ Entire Medical Record

____ Psychological Reports ____ Operative Reports

____ Consults ____ Other -Specify _____

This authorization is valid for a maximum or one year, or until expressly revoked by me. A true and exact photo static/faxed copy of this authorization shall have the same effect as the original.

_____ _____
(Signature of patient/ Legal Guardian) (Date)

Patients Date of Birth_____/_____/_____ Last Four of SSN:____ ____ ____ ____

Witness_____ Date_____