AUTHURIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT.S NAME:_____

PREVIOUS NAME:_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

I REQUEST AND AUTHORIZE_____
TO RELEASE HEALTH CARE INFORMATION OF THE PT NAMED ABOVE

NAME: **Dr Logan Oney | Dr. Stephenie Lucas | Dr. Joram Mogaka**
20870 Mack
Grosse Pointe, MI 48236
(313)885.2334
(313)647.4837 Fax

THIS REQUEST AND AUTHORIZATION APPLIES TO:

_____HEALTH CARE INFORMNATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES OF TREATMENT:
_____

_____ALL HEALTH CARE INFORMATION

_____OTHER:_____

I UNDERSTAND THAT MY EXPRESS CONSENT IS REQUIRED TO RELEASE ANY HEALTH CARE INFORMATION RELATING TO TESTING, DIAGNOSIS, AND/OR TREATMENT FOR HIV (AIDS VIRUS), SEXUALLY TRASMITTED DISEASES, PSYCHIATRIS DISORDERS/MENTAL HEALTH, OR DRUG AND/OR ALCOHOL USE, YOU ARE SPECIFICALLY AUTHORIZED TO RELEASE ALL HEALTH CARE INFORMATION RELATING TO SUCH DIAGNOSIS, TESTING, TREATMENT.

_____

SIGNATURE OF PATIENT (OR PATIENT'S AUTHORIZED REP) DATE

_____

RELATIONSHIP OR STAUS IF SIGNED BY ANYONE OTHER THAN PT. (PARENT, LEGAL GUARDIAN, PERSONAL REP., ETC.)

_____

WITNESS DATE

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED