CENTER FOR WOMEN'S SEXUAL HEALTH

Dr Stephen C Dalm
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AUTHORIZATION FOR RELEASE-PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone _____

_____ Dates of Service _____

Information Requested

History & Physical	Discharge Summary	Emergency Report	EEG/EKG
Operative Report	Lab/Path Reports	Billing Invoice	Blood Type
Radiology Report	Progress Notes	Immunizations	Consults/Letters

Other _____

I would like copies of my health information indicated in the section above sent:

From: _____ To: _____
_____ _____
_____ _____
_____ _____

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Michigan Department of Public Health rules, which include venereal diseases, Tuberculosis, Hepatitis A,B,C, Human Immunodeficiency (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and related complex (ARX) and _____ (specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental Health treatment records, psychological services, and social services information including communications made by me to a social worker, therapist, or psychologist.

It is further understood that he information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions and records from other health care providers other than Stephen C Dalm DO PC may be released unless specifically requested otherwise.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it.

Expired Date_____ or Action _____
If no express revocation is issued, this authorization will expire in 60 days from the date signed.

I understand that the Health Information that is released under this Authorization may be subject to re-disclosure by the recipient and the privacy of my Health Information may no longer be protected by the law.

A faxed copy of this Authorization shall have the same effect as the original.

_____ _____ _____
Signature of Patient or Legal Representative Date Relationship to Patient