FENTON MEDICAL CENTER

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RELEASE OF MEDICAL INFORMATION CONSENT

Date of Consent: _____

Patient Name: _____ Date of Birth: _____

I give any Fenton Medical Center representative permission to discuss and disclose my medical information with the following people:

Name of Person	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fenton Medical Center has permission to discuss all information including test results, appointment information, and recommendations in regards to my medical care. If there is any information that I do not want disclosed it is listed below. It is not the practice of Fenton Medical Center to leave medical information on an answering machine.

Exclusions to Consent:

_____

_____

_____

This consent can be revoked at any time, but must be done so in writing.
This consent will expire one year from the date above.
This consent will need to be updated yearly.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

Fenton Medical Center
102 N. Adelaide Street, Fenton MI 48430
(810) 629-2245
Fax (810) 629-6535