FENTON MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO ANOTHER PARTY

Patient Name: _____ Date: _____ DOB: _____

I give any Fenton Medical Center representative permission to discuss my medical information with the following person(s):

Name of Person: _____ Relationship to Patient: _____

Name of Person: _____ Relationship to Patient: _____

Name of Person: _____ Relationship to Patient: _____

Fenton Medical Center has permission to discuss all information including test results, appointment information and recommendations in regards to my medical care. If any exclusions, you must list below. Fenton Medical Center staff will only leave a message on an answering machine for you to return our call; no medical information will be left on an answering machine.

Exclusions:

_____

_____

_____

This consent can be revoked at any time, but must be done so in writing.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

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