FENTON MEDICAL CENTER

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REQUEST FOR MEDICAL RECORDS FROM ANOTHER FACILITY

I, _____ date of birth, _____ authorize the release of information contained in my records to be sent to:

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

Name and address where the request is being sent for request of records:

_____

_____

_____

1. Records are being sent for the purpose of :

   _____

   _____

2. Specific dates of records to be released from _____ to _____

3. Specific type of information to be disclosed subject to the provisions of 1978 Michigan P.A. 368, as amended, and the Veterans Benefits and Services Act of 1988 P.L. 100-32; Medical, Psychiatric, Psychological, Vocational records of evaluation and/or treatment for physical and/or emotional illness including past history, diagnosis, complications, and sequelae, prognosis, progress notes, medication, workshop evaluations, training reports, referring physician report, insurance reports, IQ scores, treatment plans, recommendations, summaries, current status, evaluation and treatment records of alcohol or drug abuse, sickle cell anemia, any information regarding communicable diseases, serious communicable diseases and infections which include venereal diseases, tuberculosis, hepatitis, hepatitis B, HIV infection, AIDS or ARC.

4. Any information specifically not to be released from records:

   _____

   _____

5. This consent may be revoked at anytime. It shall be valid for no longer than 30 days from the signature date which is reasonably necessary to accomplish the purpose for which it was given. I understand that the record release for the above will be treated confidentially.

_____ _____
Patient Signature Date
(If a minor, parent or guardian must sign)

This release must always be signed by a witness. Two witness are required if the statement has been signed by an "X".

_____ _____ _____
Witnessed by Date Relationship

_____ _____ _____
Witnessed by Date Relationship