AUTHORIZATION TO RELEASE PATIENT INFORMATION TO MILLIKEN MEDICAL PLLC

Patient Name:________________________ Phone Number:_______________ Date Of Birth___________

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure: ____________________
____
____

3. The type and amount of information to be used or disclosed is as follows: (include dates if applicable)
   Problem list — Most recent history and physical
   Medication list — Laboratory results from(date)_____to_____
   List of allergies — X-ray and imaging reports from(date)_____to_____
   Immunization Record — X-ray films from(date)_____to_____
   Consultation reports from(doctor's name)__________________________________
   Entire Record from(date)_______________to(date)____________________
   Other ____

4. I understand that the information in my health record may include information relating to the following: sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency Virus (HIV), behavioral or mental health services, treatment for alcohol and drug abuse, genetic testing, and I consent to the release of that information.

5. This information may be disclosed to and used by the following individual or organization:
   Dr.________________________________
   224 Circle Drive
   Traverse City, MI 49684 Fax: (231) 935-0613

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
   If I fail to specify an expiration date, even or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information to the individual or organization named above is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM

____ Dated: ______________________
Patient or Personal Representative Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient:________________________________ Print Name:__________________________