GRACE MEDICAL OF TROY
DR. NANCY MANSOUR-HABIB
Beaumont® Staff

CONSENT TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Patient's D.O.B: _____

I authorize for my medical information to be released:

From: _____ Address: _____

Phone ( ) - Fax ( ) -

To: _____ Address: _____

Phone ( ) - Fax ( ) -

____ Entire Medical Record, INCLUDING Information related to the treatment for substance abuse or dependency: Psychiatric or mental health treatment. Information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ Entire Medical Record, Excluding (check appropriate 0) Information related to the treatment for 0 substance abuse or dependency 0 psychiatric or mental health treatment. Information related to testing or treatment of 0 sexually transmitted diseases and 0 HIV/AIDS.

____ Record of care from _____ to _____ INCLUDING Information related to the treatment for substance abuse or dependency. Psychiatric or mental health treatment information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ Record of care form _____ to _____ EXCLUDING Information related to the treatment for (check appropriate)
__ Substance abuse or dependency __ Psychiatric or mental health treatment

Information related to testing or treatment of
__ Sexually transmitted diseases __ HIV/AIDS

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, Payment, Enrollment, or Eligibility for benefits).

This applies to all information in my medical record protected under the regulation in 42 codes of Federal Regulations. Part 2

I understand this release is effective until _____, but that I may revoke my consent at any time by providing written consent to the above named party.

Patient's Signature: _____

Witness Signature: _____