



Comprehensive Ear, Nose and Throat, P.C.

1179 East Paris Ave. SE. #100
Grand Rapids, MI. 49546
ph: (616) 942-0380
fax: (616) 942-8640

Authorization For Release of Medical Records To:

Comprehensive Ear, Nose and Throat, PC.
1179 East Paris Ave. SE. #100 Grand Rapids, MI. 49546

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

City State Zip.

- I authorize _____ to release information contained in my records, including as applicable:

_____ Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules (which include Venereal Disease 'VD', Tuberculosis, 'TB', Hepatitis B, Human Immunodeficiency Virus 'HIV', Acquired Immunodeficiency Syndrome 'AIDS', and _____.

Specify other, if known.

_____ Alcohol and Drug Abuse Treatment information protected under the regulation in code 42 of Federal Regulations, part 2.

- Other information requested:
 - () Clinical Notes
 - () Laboratory Reports
 - () Other records. Please specify:

- Purpose of Disclosure: () Continued patient care
() Other _____

It is further understood that the information released is for the specific purpose stated above, and may not be provided in whole or in part to any other agency, organization or person without written consent.

This authorization shall be in force and effect until _____
[specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure] at which time this authorization to use or disclose this protected health information expires. ["End of the research study" and "none" is acceptable for authorization for research purposes.]

Signature of Patient or Representative: _____

Date: _____ Witness: _____