

# DELTON MEDICAL CENTER

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, \_\_\_\_\_  
Patient Name Date of Birth

Authorize: \_\_\_\_\_  
Name of Facility/Provider

\_\_\_\_\_  
Address City State Zip Code

To release the following information to:

Delton Medical Center  
11320 S. M-43 Hwy, P.O. Box 675, Delton, MI 49046  
Phone #: 269-623-5521 Fax #: 269-623-5527

Please check:

- Any and all of my medical record (as of the date of this release)  
 Only the following information: \_\_\_\_\_

This release also specifically allows the release of the following information (this information will not be released unless the appropriate is initialed):

- Any record of treatment for drug and/or alcohol dependency or abuse  
 Any record of mental health treatment  
 Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases

This information is being released for the following purpose(s) only: \_\_\_\_\_,  
and may not be used for any other purpose or related to any other person(s) with my written consent.

If you are transferring your care to another provider, please check the following:

- Moving out of town  
 Dissatisfied  
 Other, please explain: \_\_\_\_\_

This release is effective for six months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the above named party. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request.

\_\_\_\_\_  
Patient/Legal Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date