JOHN R. CLARK, MD PC
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please Print

_____ _____ _____
Patient Name | Possible other names used | Date of Birth

I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION

☐ **From** ☐ **To**

JOHN R. CLARK, MD PC
600 S LAKEVIEW STE 207
STURGIS, MI 49091
PHONE: 269-659-4646
FAX: 269-651-2210

☐ **From** ☐ **To**

Name of person, Physician or Practice:_____

Address: _____

_____

Fax #: _____

Specific Information to be disclosed:

☐ Office Notes ☐ Test Results ☐ Operative Reports ☐ Pathology Reports

☐ Complete OB records for current/ most recent pregnancy ☐ Pap smear results X _____years

☐ _____

This release also specifically allows the release of the following sensitive information. If you authorize the release of the sensitive information described below, please **INITIAL** inside the appropriate box:

_____ Any record of treatment or testing for drug and/or alcohol dependence or abuse

_____ Any record of mental health treatment, included prescriptions

_____ Any record of testing, care, treatment, reporting, or research pertaining to infection with HIV/AIDS

Purpose of release: ☐ Transfer of care to another provider ☐ Second Opinion ☐ _____

Condition Currently being evaluated: _____

I understand there is a possibility the information may be redisclosed by the recipient and no longer protected under the federal privacy rules. 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.

This release is effective for one year from the date of execution; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

_____ _____
Patient Signature/Legal Representative Signature ☐Parent ☐Guardian ☐_____ Date

_____ _____
Witness Date