

Karim HealthCare
605 W. Chicago St., Ste 2, Coldwater, MI 49036
(P):517-924-1444 – (F):517-924-1445

Authorization for Release of Medical Information

I, _____
Patient Name Date of Birth

Authorize _____
Name of Facility/Provider

Address City State Zip

To release the following medical information to _____
Name of Facility/Provider

Address City State Zip

Phone Fax

SPECIFIC INFORMATION TO BE DISCLOSED:
____ Progress Notes ____ Test Results ____ Chart (last 3 yrs)
____ Other _____

PLEASE INITIAL APPROPRIATE LINES:
This release also specifically allows the release of the following information (will not be released unless the appropriate line is initialed):
____ Any record or treatment for drug and or alcohol dependency or abuse
____ Any record of mental health treatment
____ Any record of testing, care, treatment including research pertaining to infection with HIV or AIDS

Authorization valid for ____ This request only ____ One year from the date of this authorization

- I understand that**
- I may revoke this authorization at any time by submitting a *written* request to the address above except where disclosure was established by my authorization.
 - I may be charged for records if asking for entire chart.

I _____ authorize this information to be sent via FAX transmission
(Urgent request only)

If you are transferring your entire care to another provider, please mark appropriately:
____ Moving out of town ____ Transferring care ____ Insurance purpose
____ Dismissed ____ Consult only ____ Provider inquiry
____ Other, please explain _____

Patient/Legal Guardian of Patient Date

Karim HealthCare staff Date