Consent to Release Medical Information

Request going to:

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Please send records to

Oakland Ophthalmic Surgery, PC
800 South Adams, Suite 201
Birmingham, MI 48009
Phone 248-644-8060
Fax 248-644-5081

PRINT Patient's Name | Date of Birth | Physician requesting information

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 from __________________ to ________________________
EXCLUDING 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.

If deemed necessary by Doctor, I authorize this information to be sent via FAX transmission.

This applies to all information in my medical records protected under Federal Regulation (42C.F.R. Part 2).

I authorize medical information to be released as indicted above, I understand this release is effective until ____________________ but I may revoke my consent at any time by providing written consent to the above named party.

______________________________ ________________________
Patient or Patient's Legal Guardian Date

______________________________ ________________________
Witness Date

I request Oakland Ophthalmic Surgery, PC to release my medical records to the following Physician or Health Institution:

Name ____

Address ____

Phone number____

PRINT Patient's Name Date of Birth Physician requesting information

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 from ___________________ to _________________________
EXCLUDING 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.

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_______________________________ _________________________
Patient or Patient's Legal Guardian Date

_______________________________ _________________________
Witness Date