AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I, _	, hereby authorize:	
	Comprehensive Women's H 51 S. Washington St., Suite E Oxford, MI 48371	ealth, P.C. 1157 S. Adams Rd. Birmingham, MI 48009
incl if an mad and can	Director or designee, or Medical Information Department to releated uding alcohol and drug abuse records protected under the regularity; psychiatric/psychological service records, if any; and social worker or psychiatrist/psychologist, and any it serious communicable diseases and infections as defined by Michigan include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any y under the conditions listed below:	tions in Code 42 of Federal Regulations, Part 2, ork records, if any, including communications information regarding communicable diseases higan Department of Public Health rule, which
Pat	ient's Phone Number: ()	Patient Birthdate://
1.	Name of Person(s) or Organization(s) to whom disclosur	e is to be made:
	Name	Phone (include area code)
	Address	Fax (include area code)
2.	Specific type of information to be disclosed:	
	Dated from:	Dated through:
	Physician notes	Labs
	Operative reports	Ultrasound/Radiology reports
	Most recent Pap smear	Most recent mammogram report
	Other:	-
3.	The purpose and need for such disclosure:	
	Continuation of treatment or health care	Insurance Investigation
	Billing Information	Social Service Referral
	Disability Determination	Billing Information
	Other:	
4.	Information is to be:Mailed	_FaxedPicked Up
	If pickup is checked, by whom (name):	
	(If pickup is by someone other than patient, include letter or authorization, if necessary)	
	Customary copying fees and postage may be charged to the patient.	
5.	This authorization is subject to written revocation at any time except to the extent that Dr. Powell has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested information.	
Signature of Patient/ Parent of a Minor/ Authorized Representative		
		D .
		Date: