

CONSENT TO RELEASE MEDICAL INFORMATION

Troy Family Practice, P.L.L.C.
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Stacey Beltz, D.O.
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Patient's Name: _____ Birthdate: _____

Records Requested From: _____

I authorize the release of my medical records to the above named practice, these records are to
_____ **include or** _____ **exclude** information relating to the treatment of substance abuse or dependency;
psychiatric or mental health treatment; information related to testing or treatment for sexually transmitted
disease including HIV/AIDS.

My above choice applies to all information in my medical record protected under HIPPA.

These records are being requested for the following reasons:

- _____ Moving to a new area
_____ Seeing a specialist
_____ Insurance change
_____ Other, please comment:

I may revoke this consent at any time by written request and understand that the release is effective for six
(6) months. Records forwarded from a previous physician and generated before my relationship with Troy
Family Practice P.L.L.C. may be released with the authorization of either Shawn P. Syron, M.D., Stacey
Beltz, D.O., or Harjaneet Bedi, M.D.

(Signature of Patient or Patient's Legal Guardian)

(Date)

(Signature of Witness)

(Date)

PLEASE MAIL RECORDS, DO NOT FAX