Consent To Release Medical Information

Troy Family Practice, PLLC

2041 E Square Lake Rd. Suite 300
Troy, MI 48085
Office (248) 813-0124
Fax (248) 879-0148

Stacey Beltz, DO David Pawlowski, DO,
Ann Forde, NP-C Kathrine Kranz, PA-C Brittany David, PA-C

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 ***WE ARE THE PATIENT'S PRIMARY CARE PHYSICIAN'S OFFICE***

_____ Seeing a specialist

Please DO NOT fax records if greater than 20 pages!

_____ Insurance change

_____ Update primary care provider/office

_____ 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, PLLC., may be released with the authorization of either Stacey Beltz, DO, Ann Forde, NP- C or Kathrine Kranz, PA- C.

_____

(Signature of Patient or Patient's Legal Guardian) (Date)

_____

((Signature of Witness) (Date)