Authorization To Release Medical Information

Records may be released to: Greenlight Wellness
G 4440 South Saginaw St Burton, Mi 48439
Phone 810.407.5555 Fax 810.479.0881

DO NOT SEND ENTIRE MEDICAL RECORD

Please, send only those records which the patient has authorized, below.

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

Office Phone: _____
Office Fax: _____

I authorize _____, _____
(Doctor/Provider/Clinic Name) (Clinic/Provider Address)
to release medical information for:

Patient Name: _____ **Date of Birth:** _____
Patient Telephone Number: (___) _____ **Social Security Number:** _____
Area Code

to the office of Mitchell A. Cohn, D.O. Information will be used for continuity of patient care relating to the following medical condition(s): [Please check all that apply.]

__ Cancer
__ Amyotrophic Lateral Sclerosis
__ Agitation of Alzheimer's disease
__ Cachexia or Wasting Syndrome
__ Severe and Persistent Muscle Spasms
__ Glaucoma
__ Hepatitis C
__ Nail patella
__ Severe and Chronic Pain
__ Other (Specify): _____
__ HIV/AIDS
__ Crohn's disease
__ Severe Nausea
__ Seizures

By **INITIALING NEXT TO EACH ITEM, BELOW**, I specifically authorize release of the following:

INITIAL HERE:

_____ Clinician office chart notes **[MOST RECENT THREE (3) VISITS ONLY WHICH PERTAIN TO CONDITION(S), ABOVE]**
_____ Diagnostic imaging reports (NOT FILMS) **[LAST 3 YEARS, ONLY]**
_____ *HIV/AIDS related records **[LAST 3 YEARS, ONLY]**

PLEASE SEND THIS FORM WITH MEDICAL RECORDS

Please choose one permission statement, below, and initial only that one.
_____ **You have my permission to FAX the requested information.**
_____ **You may MAIL the information, but NOT FAX it.**

This authorization may be revoked at any time. The only exception is when action has been take in reliance of the authorization. Unless otherwise revoked, this authorization will expire 12 months from the date of signing. I understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

FEES: Please bill me for costs, if any, associated with providing copies of my records, and I will remit payment promptly upon receipt of the records.

Patient Signature: _____ Date: _____