

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ **Date of Birth:** _____

Social Security #: _____ **Phone #:** _____

I request and authorize _____
(Doctor/Provider/Clinic Name & Address)

To release healthcare information of the patient named above to:

**Advanced Medical Associates
P.O. Box 330
Lambertville, Mi. 48144
(734) 347-2127
www.amamichigan.com**

This request and authorization applies to healthcare information relating to the following treatment or condition. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Agitation of Alzheimer’s Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Nail Patella |
| <input type="checkbox"/> Cachexia or Wasting Syndrome | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Severe & Chronic Pain |
| <input type="checkbox"/> Crohn’s Disease | <input type="checkbox"/> Severe & Persistent Muscle Spasms |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Severe Nausea |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Other (Specify): _____ |

I understand that;

- 1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.**
- 2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.**

Patient Signature: _____ **Date:** _____

Print Name: _____

**THIS AUTHORIZATION EXPIRES SIX MONTHS
AFTER IT IS SIGNED.
A FAX/copy of this authorization shall be considered as
valid as the original.**