_____
Date of Request

AUTHORIZATION FOR RELEASE OF INFORMATION

Patients Name: _____ Date of Birth: _____

Address: _____

I Authorize: ☐ John M. Stafford M.D. & Associates P.C. ☐ _____
3800 Hollywood Rd. Suite 101 _____
Saint Joseph, MI 49085 _____
Phone: (269) 428-2552 Fax: (269) 428-2943

To Release The Following Information From My Medical Record To:

☐ John M. Stafford M.D. & Associates P.C. ☐ _____
3800 Hollywood Rd. Suite 101 _____
Saint Joseph, MI 49085 _____
Phone: (269) 428-2552 Fax: (269) 428-2943

☐ **All Records from the last 5 years,** including all the following: **(Cross out any records you do not want sent)**
- medical progress notes, labs, x-rays, diagnostics, etc.
- records specific to HIV infection, acquired immune deficiency syndrome, AIDS
- records regarding alcohol or drug abuse or any chemical dependency treatment or counseling
- records requiring mental health treatment or counseling

☐ **"Limited Records", Including only the following:**

_____

_____

Purpose of disclosure:
☐ Consultation ☐ Changing Doctors
☐ Family Doctor ☐ Insurance Company
☐ Personal Use ☐ Attorney/ Legal
☐ Other: _____

This release is effective for 30 days from date of execution; however, it may be revoked at any time by providing notice, in writing, to the above-named party.

Signature: _____ **Date:** _____
Patient/ Legal Guardian of Patient

Witness Signature: _____