Praveen Modi, M.D., P.C.
9857 Haggerty Rd
Plymouth, MI 48170
Telephone: 734-680-8889
Fax: 734-228-4028

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ request and authorize _____to release healthcare information pertaining to me.

Specific Type of Information To Be Disclosed:

_____ History & Physical
_____ Office Notes
_____ Consultations
_____ Laboratory Report
_____ Radiology Results
_____ Operative Notes
_____ Pathology Report
_____ Other_____

Dates of Treatment_____
_____

The Purpose and Need For Such Disclosure:
Continuation of Care

Definition: Sexually Transmitted Disease (STD) as defined by law, TCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, genital wart, condyloma, Chlamydia, non-specific arthritis, syphilis, VDRL, Immunodeficiency Syndrome and gonorrhea.

Yes/No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

For Mental Health Records, a statement is necessary as to how the information to be disclosed is germane to the purpose for the disclosure.

Yes/No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

_____ _____ _____
Signature of Witness Date Signature of Patient or Patients Representative

_____
Patients Date of Birth