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.

__ Agitation of Alzheimer's Disease
__ Amyotrophic Lateral Sclerosis
__ Cachexia or Wasting Syndrome
__ Cancer
__ Crohn's Disease
__ Glaucoma
__ Hepatitis C
__ HIV/AIDS
__ Nail Patella
__ Seizures
__ Severe & Chronic Pain
__ Severe & Persistent Muscle Spasms
__ Severe Nausea
__ 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.