LAKE SUPERIOR
STATE UNIVERSITY
Health CARE Center
650 W. Easterday Ave.
Sault Ste. Marie, MI 49783

Phone: 906-635-2110
Fax: 906-635-0337

CONSENT TO RELEASE MEDICAL INFORMATION

Patient: _____ Birth date: _____
Last *First*
Social Security #: _____

Provider releasing records:

Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____

Provider to receive records:

Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____

Medical information to be sent:

❑ Specific records to be released include: _____

❑ Entire medical record
INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health; and testing of sexually transmitted diseases and HIV / AIDS.

❑ Entire medical record
EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health; and testing of sexually transmitted diseases and HIV / AIDS.

❑ Records of care from: _____ to: _____
INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health; and testing of sexually transmitted diseases and HIV / AIDS.

❑ Records of care from: _____ to: _____
EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health; and testing of sexually transmitted diseases and HIV / AIDS.

❑ If deemed necessary by _____, I authorize this information to be sent via fax transmission.
Provider

This applies to all information in medical record protected under regulation in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above.
I understand this release is effective until _____ , but that I may revoke my consent at any time by providing written consent to the above named party.

_____ _____
Patient or Patient's Legal Guardian Date

_____ _____
Witness Date