MPCP MICHIGAN PRIMARY CARE PARTNERS | WMP WEST MICHIGAN PAIN | WMSC WEST MICHIGAN SURGERY CENTER

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Reed City, MI 49677
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AUTHORIZATION FOR RELEASE OF INFORMATION MEDICAL AND BILLING

Name: _____ Date of Birth:_____

I hereby authorize _____ to release my medical/billing

information to: _____

Address of Recipient: _____ _____
Street City

_____ _____
State Zip

Copies of my medical records, including any information regarding medical, psychiatric, alcohol, drug testing or treatment, AIDS, AIDS –related complex (ARC), HIV infection or billing summaries related to any such conditions, are requested and authorized to be released.

This release is subject to such limitations as indicated below:

- ❑ Confined to records regarding treatment for the following medical conditions or injuries: _____
- ❑ Which occurred on or about this date: _____
- ❑ Confined to the following information: _____
- ❑ Covering records for the period of: _____
- ❑ Itemized detailed billing information: _____

I understand that I have the right to revoke this consent at any time unless information has already been released in reliance upon my previous consent. Submitting a written notice of revocation to the releasing party may revoke my consent. I understand this authorization is only valid for the date of signature and prior; no future dates or records will be released.
I hereby release _____, its employees, staff and agents from any liability which may arise as a consequence of the disclosure of the information set forth above relating to my medical/billing records.

Signature: _____ Date: _____
Patient or guardian

Witness: _____ Date: _____

Any subsequent disclosure of medical/billing information by the recipients is prohibited without the express written consent/authorization from the above-named patient/guardian.