# Authorization for Release of Medical Information

**Release TO:** **Jackson & Bigelow, MD - PC** **(989) 631-2020**
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**Midland, MI 48642-8636** **Fax: (989) 835-6686**

## DO NOT FAX IF MORE THAN 20 PAGES.
## WE REQUIRE RECORDS MAILED IF MORE THAN 20 PAGES.

**Pt Name:** _____ **Date of Birth:** _____

**Address:** _____ **Telephone #:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**I authorize _____ to release information contained in my patient records, including as applicable:**

- ❑ **All Records for All Dates of Service** **- OR -**

**Specific Items:**

- ❑ **Office Notes**
- ❑ **Visual Field Tests and OCTs**
- ❑ **Lab Reports**
- ❑ **Radiology / Imaging Reports**
- ❑ **History & Physical**
- ❑ **Consultation Reports**
- ❑ **Discharge Summary**
- ❑ **ER Reports**
- ❑ **Operative & Pathology Reports**
- ❑ **Records related to specific problem and/or specific date _____**
- ❑ **Other _____**

**For:**
- ❑ **All Dates of Service**
- ❑ **Or Specific Date(s) of Service: _____**

**I specifically authorize release of:**

**Information about communicable disease and serious communicable disease and infection, as defined by statue and Michigan Department of Health Rules (which include venereal disease, "VD", "TB", Hepatitis B, Immunodeficiency virus, "HIV", HIV test, acquired immunodeficiency syndrome, "AIDS", and AIDS related complex, "ARC".) Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. Mental health treatment records, psychological services and social services information including communications made by me to a social worker or psychologist. Mental health treatment records, psychological services and social services information including communications made by me to a social worker or psychologist.**

**Purpose of Disclosure:** **Patient Care, unless the following is checked:**
- ❑ **Other: _____**

**It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person.**

_____ _____
**Signature** **Date**

_____ _____
**Witness** **Relationship to Patient**

Revised 8/1/2026