West Shore Eye Care

409 W.Ludington Avenue
Ludington, MI 49431
231-843-4117
Fax 231-843-7631

Records Release Authorization

I_____of_____
(Patient's Name) (Address)

_____,_____
(City) (State) (Zip) (Date of Birth)

hereby authorize_____to release medical information, including communicable disease and serious communicable diseases and infection as defined by statue and Michigan Department of Public Health Rules (which include Venereal Disease, Tuberculosis, Hepatitis-B, Human Immunodeficiency Virus, HIV Test, Acquired Immunodeficiency syndrome, AIDS related Complex, Mental Illness and other if known. Also including alcohol and drug abuse records protected under the regulations in 42 Code of the Federal regulations, Part 2 or any information which may pertain to the diagnosis, evaluation, or treatment of the above named patient.

Released to: _____

_____

_____

_____

_____ _____
Signature of Patient Witness' Signature

_____
Date