Michigan **Holistic Health**

OFFICE USE ONLY:
New _____ MHH Exp. _____ Additional _____

Please send to :

Dr. David A. Crocker
500 W. Crosstown Parkway
Kalamazoo, MI 49008
Phone toll free 1-855-420-8100
FAX TO: 269.382.1197

PURPOSE OR NEED FOR THE INFORMATION REQUESTED IS CONTINUING MEDICAL CARE

MEDICAL RECORDS RELEASE FORM

Patient's name _____ Date of Birth _____/_____/_____

Street Address _____ SS # _____

City_____ State _____ Zip_____ Phone (_____)_____

I voluntarily consent and allow the organization named below to release healthcare information to Dr. David Crocker of Michigan Holistic Health to get information from:

Primary Doctor's name: _____

Doctor's Office Location/Name of Practice: _____

Doctor's Phone #: _____ Medical Records Dept. Fax #: _____
(required) (if available)

INFORMATION TO BE RELEASED

1. Most recent history & physical
   AND
2. Office notes from the 5 most recent visits pertaining to _____
   (qualifying condition)

PURPOSE OR NEED FOR THE INFORMATION REQUESTED IS CONTINUING MEDICAL CARE

I understand this consent is voluntary and that I may revoke this authorization at any time by providing written notice to the above named party. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

Patient signature: _____ Date signed: _____