

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

PONTIAC OSTEOPATHIC HOSPITAL  
50 NORTH PERRY STREET  
PONTIAC , MI 48342-2253  
Phone: (248)338-5000 EXT 5625 / 5163  
FAX: 248-338-5018

I,  
hereby authorize POH Medical Center to release information contained in my medical records to:

Name: MINUTE MAN PROCESS AND LEGAL SERVICE  
Attn:  
Address: 3318 N MAIN  
ROYAL OAK, MI 48073  
Phone: 248-585-6300 Fax:

**SPECIFIC INFORMATION TO BE DISCLOSED:**

This may include information about communicable disease and/or serious communicable disease and/or infections as defined by Michigan statute and Department of Public Health rules, which include Human Immunodeficiency Virus(HIV) infection, Acquired Immunodeficiency Syndrome (AIDS),AIDS Related Complex (ARC),venereal disease and tuberculosis, if any: alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal regulations, Part 2, if any: psychiatric/psychological records, if any: social work records, if any; including communications made by me to a social worker/ psychiatrist/psychologist.

**COMMENTS:** \_\_\_\_\_

This authorization must be signed subsequent to the hospitalization you are requesting and is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate 60 days from the date of signing. A photocopy or electrostatic copy will have the same authority as the original. Any redisclosure of medical information is prohibited by the recipients(s) unless otherwise specified in this authorization.

Subscribed and sworn before me this  
Day \_\_\_ of \_\_\_\_\_, 20\_\_\_\_  
\_\_\_\_\_  
Notary Public, \_\_\_\_\_ County, MI  
My Commission expires: \_\_\_\_\_  
Acting in the County of: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient / Parent of Minor  
or Authorized Representative.  
Date Signed: \_\_\_\_\_  
\_\_\_\_\_  
Witness / \_\_\_\_\_  
Date