THE WELLNESS PLAN
Live And Be Well.

Side A

☐ EAST AREA HEALTH CENTER, 4909 E. Outer Drive, Detroit, MI 48234 (313) 366-2000
☐ NORTHWEST HEALTH CENTER, 21040 Greenfield, Oak Park, MI 48237 (248) 967-6500
☐ GATEWAY HEALTH CENTER, 2888 W. Grand Blvd., Detroit, MI 48202 (313) 875-4200
☐ E. BONNER HEALTH CENTER, 10101 Fenkell, Detroit, MI 48238 (313) 491-4300

AUTHORIZATION FOR THE RELEASE OF INFORMATION REGARDING COMMUNICABLE OR SERIOUS COMMUNICABLE DISEASE OR INFECTION WHICH MAY BE CONTAINED IN MY MEDICAL RECORD

I, _____ _____ _____ _____
(PATIENT NAME) (SOC. SEC. NO.) (BIRTH DATE) (HPID)

authorize the following: (hospital, clinic, agency, school, other)

MEDICAL RECORD DEPARTMENT
THE WELLNESS PLAN
2888 W. GRAND BLVD.
DETROIT, MICHIGAN 48202

or its director, designee or medical record department to release information regarding communicable or serious communicable disease or infection which may be contained in my medical record as specified on lines 2 thru 5 below. Consistent with Michigan Public Act 488 of 1988, this authorization allow for the disclosure of any information in my medical records pertaining to HIV testing, HIV infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), venereal disease and/or other communicable or serious communicable disease or infection when so specified.

1. **Party to whom information is to be released:**

Name or title	RECORDS DEPOSITION SERVICE, INC.
	120 W. MADISON ST., STE. 300
Address	CHICAGO, IL 60602
	P: 312.553.8900 F: 312.553.8901
City, State, Zip	

2. **Specific type of information to be released (for example, gonorrhea, HIV infection, AIDS related complex, herpes, other.) Patient must initial this line or specify, in his or her own handwriting, the type of information to be released.**

_____

3. **Time period covered** _____ 20_____ **thru** _____ 20 _____

4. **The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other):**

_____

5. **This authorization shall have a duration no longer than that which is reasonably necessary to effectuate the purpose for which it is given, and unless revoked by me in writing prior to this time, will expire automatically for the reason(s) specified below:**

Date _____

Event _____

Condition _____

SIGNATURES		
PATIENT OR GUARDIAN		DATE
WITNESS		DATE

THE WELLNESS PLAN
Live And Be Well.

Side B

☐ EAST AREA HEALTH CENTER, 4909 E. Outer Drive, Detroit, MI 48234 (313) 368-2000
☐ NORTHWEST HEALTH CENTER, 21040 Greenfield, Oak Park, MI 48237 (248) 967-6500
☐ GATEWAY HEALTH CENTER, 2888 W. Grand Blvd., Detroit, MI 48202 (313) 875-4200
☐ E. BONNER HEALTH CENTER, 10101 Fenkell, Detroit, MI 48238 (313) 491-4300

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ _____ _____ _____
(PATIENT NAME) (SOC. SEC. NO.) (BIRTH DATE) (HPID)

authorize the following: (hospital, clinic, agency, school, other)

MEDICAL RECORD DEPARTMENT
THE WELLNESS PLAN
2888 W. GRAND BLVD.
DETROIT, MICHIGAN 48202

or its director, designee or medical record department to release information from my medical records as specified below which may include records of my medical/surgical care; venereal disease information; psychiatric, psychological and/or social services information including communication made by me to a psychiatrist, psychologist and/or social worker; substance abuse information protected under 42 Code of Federal Regulations Part 2 or other information as specified.

1. Party to whom information is to be released:

Name or title

Address RECORDS DEPOSITION SERVICE, INC.
120 W. MADISON ST., STE. 300
CHICAGO, IL 60602
P: 312.553.8900 F: 312.553.8901

City, State, Zip

2. Specific type of information to be released (for example, medical, mental health, social services, other):

_____

3. Time period covered _____ **20**_____ **thru** _____ **20** _____

4. The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other):

_____

5. This authorization shall have a duration no longer than that which is reasonably necessary to effectuate the purpose for which it is given, and unless revoked by me in writing prior to this time, will expire automatically for the reason(s) specified below:

Date _____

Event _____

Condition _____

SIGNATURES

PATIENT OR GUARDIAN		DATE
WITNESS		DATE