McLaren Ambulatory Care Center,
McLaren Occupational Health and/or Convenient/Prompt Care Center
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Birth Date: _____ / _____ / _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Telephone #: (_____) _____

Maiden or other Names: _____

I authorize Tuscola Physicians (name)
714 S. Trumbull St. (address)
Bay City, MI 48708 (city, state, zip)
(989) 893-5541 (telephone)

to release to Harmohan Kochar, M.D. (name)
3720 Katalin Ct., Suite 101 (address - (Inc. Suite # if appl.)
Bay City, MI 48706 (city, state, zip)
(989) 391-9223 (telephone)

health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). *This health information is referred to herein as "Protected Health Information."*

Specific information to be disclosed:

Last 3 clinic notes; Echo test results; Carotid test results; Dexa Scan results; Most recent lab results; Most recent CT Scan; Most recent stress test results

The purpose and need for such disclosure:
Continuation of care

(For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is germane to the purpose and need for such disclosure.)

Expiration date or event: _____.

You have the right to revoke this Authorization except if action has already been taken in reliance upon this Authorization. You may revoke your Authorization by submitting a request in writing to: McLaren Medical Management, Inc., ATTENTION: Privacy Officer, G-1080 N. Ballenger Hwy., Flint, MI 48504.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I UNDERSTAND THAT TREATMENT OR PAYMENT MAY NOT BE CONDITIONED BASED ON THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. FURTHER, I AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE TERMS OF THIS AUTHORIZATION.

Signature (patient): _____ Date: _____ / _____ / _____

Printed (patient): _____

Signature (Authorized Representative): _____ Date: _____ / _____ / _____

Description of Authorized Representative's authority to sign for the patient:

_____