Jeffrey S. Leider, M.D., P.C.
24001 Orchard Lk. Rd. * Suite 170 * Farmington, MI 48336
Telephone: 248-615-4368 Fax: 248-615-4342

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name:_____
Patient Address:_____
Date of Birth:_____/_____/_____ SS#_____ ID#_____

TO RELEASE PATIENT INFO
( ) I authorize Dr. Jeffery Leider, M.D.
To release copies of my medical records
As listed below:
_____
_____
_____
_____
_____

MEDICAL RELEASE
( ) I authorize_____
_____
_____
to release the information listed below.
Please send it to the following address:
Jeffery S. Leider, M.D., P.C.
24001 Orchard Lake Rd., Suite 170
Farmington, MI. 48336
Phone: 248-615-4368
Fax: 248-615-4342

The specific extent or nature of information to be disclosed including alcohol and drug abuse records Protected under the Regulation in 42 Code of Federal Regulation (CFR), Part II, psychological services records, social service records, psychiatric records, if any, is (check one or more):

( ) Entire record since_____
( ) Inpatient record of _____
( ) Emergency care record_____
( ) X-Ray films_____
( ) HIV (AIDS) testing_____
( ) Other_____

This authorization is valid only if received by Dr. Jeffery Leider, MD within 90 days of the date signed. I may revoke this authorization at any time, except to the extent that records have already been released pursuant to this authorization. For all records protected by 42 CFR, this authorization will expire without express revocation 30 days after the information has been released. Any redisclosure of this information is not permitted without specific authorization to do so.

_____ _____
Witness Signature Patient, Parent of Minor, or Legal Guardian signature

_____
Date Signed