East Bay Medical
David May, D.O.
6100 US 31 N
Williamsburg, MI 49690
P.O. Box 363
Acme, MI 49610

Phone: 231-938-7968
Fax: 231-346-6044
eastbaymedical@hotmail.com

MEDICAL RECORD RELEASE FORM

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to East Bay Medical :

Name: _____ Telephone#: _____

Address: _____ Fax#: _____

_____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

_____ _____
Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.