Grunberger Diabetes Institute

Authorization to Release Health Care Information

Patient Name: ____

Address: ____

City, State, Zip: ____

Phone: _______________________

Date of Birth:____________________

I authorize:

Name: ____

Address: ____

City, State, Zip: ______________________________________

Phone #: ____________________ Fax #: ____________________

to release information regarding my medical care and treatment to:

Grunberger Diabetes Institute
43494 Woodward Avenue, Suite 208
Bloomfield Hills, MI 48302
Telephone: 248-335-7740
Fax: 248-338-7979

I consent to the release and disclosure of all my medical information, including immunization records, HIV testing/results, mental health/chemical dependency and any infectious disease records. I consent to the transmission of my medical records via a fax machine.

____________________________________ ________________
Signature of patient of authorized representative Date signed

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Witness

10/3/03