Third Coast Family Practice
Craig Matheson, D.O.

Authorization for Release of Medical Information

I Hereby Request:
Third Coast Family Practice
Craig Matheson, D.O.
821 West US 10
Scottville, MI 49454
Phone: 231-757-2500
Fax: 231-757-9073

To Release Records To:

_____

_____

_____

To release the medical records of the person listed below:

_____
Full Name of Patient Date of Birth

Reason for Release: ___Transferring Care ___Coordination of Care ___Personal Health Record___ Other
List records released:

_____
_____
_____

This authorization is subject to the following limitations:

_____Confined to records regarding treatment for: _____
Medical condition or injury/date

_____Confined to records from _____to_____
Date Date

_____No limitations on dates, history of illness, or diagnostic and/or therapeutic information; were including any treatment for alcohol and/or drug abuse. This also includes information on AIDS and ARC(AIDS related complex) and psychiatric reports if any.

This authorization must be signed by the patient if the patient is 18 yrs or older. For children under age 18, this authorization must be signed by custodial parent/legal guardian. This Release is good for one year from the date signed.

Signature: _____

Relationship to patient: _____Date:_____

Witness: _____