STANLEY S. ROLAND, D.O., P.C.

The Dermatology and Cosmetic Care Center

610 North Main
Lapeer, Michigan 48446
810-667-9000

174 South Main
Romeo, Michigan 48065
810-752-4100

Patient Information Release Authorization

Patient ______________________________ Date of Birth ____________

Address ______________________________ SS# ____________________

I, ______________________________, hereby authorize Stanley S. Roland, D.O., to release all information contained in my patient records, including (unless noted in #2 below):

____ Information about communicable diseases and infections, as defined by the statute and the Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis, human immunodeficiency virus "HIV", acquired immunodeficiency disease syndrome "AIDS", and the AIDS related complex "ARC").

____ Any information regarding substance abuse treatment protected by the regulations in Code 42 of Federal Regulations, part 2.

____ Mental health treatment records, psychological services and social services information, including any communication made to me by a psychiatrist, psychologist, social worker, nurse or other mental health care provider.

The information contained in my patient records may be released to the individual(s) or organization(s) listed below and only under the condition listed below.

1. Name and address of individual(s) or organization(s) to whom disclosure is to be made:
   ____
   ____
   ____
2. Specific information not to be released: ______________________________
   ____
3. Purpose and need for record release: ______________________________
   ____
4. This authorization is valid only if received within 90 days of the date signed and may be revoked anytime, except to the extent that the records have already been released pursuant to this authorization. For all records protected by Code 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.

____
Signature of Patient, Parent or Guardian

____
Witness

Date signed: ____________________

Date Copied and Released: ____________