Medical Release/Disclosure Form

Due to HIPPA regulations we here at West Bloomfield Internal Medicine can only release your medical information to the names you give us. Please fill out this form which gives us permission to speak to a **Family or Friend** about your health records. If the name is not on this form, we will not be able to release any information in person or on the phone.

****** THIS EXCLUDES YOUR DOCTORS******

NAME	BIRTHDATE	RELATIONSHIP

Patient Signature: _____

Print Patient Name: _____

Date: _____