SOUTH VALLEY INTERNAL MEDICINE

DR. JONATHAN LOVY, D.O., F.A.C.O.I

I, _____,

(PLEASE PRINT NAME)

authorize **South Valley Internal Medicine** to disclose any health information to the following person(s):

_____

_____

_____

_____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

Signature _____ Date _____