WOMEN'S
OB·GYN P.C.

5400 MACKINAW ROAD - SAGINAW - MICHIGAN 48604 - PH 989-792-3100 - FAX 989-792-9860
600 NORTH MAIN - FRANKENMUTH - MICHIGAN 48734 - PH 989-652-1460 - FAX 989-652-1461
Visit us at our website– www.womensob.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, (PATIENT'S NAME/MAIDEN) _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Authorize the following party:

_____

_____

_____

to release all information and/or specified information contained in my patient records, **including as applicable**: Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Health Rules (which include venereal disease "VD", tuberculosis "TB", Hepatitis B, Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS", and AIDS Related Complex "ARC", and, specify other if known.) If you would like all of your records sent, please state "All".

_____

_____

Subject matter **not to be released** as part of this authorization is: _____

_____

This information should be released to:

_____

_____

_____

Are you transferring your care to another physician? ☐ Yes ☐ No Why are you transferring your records?

_____

This authorization also allows the release of information via fax machine to the above named party(s).

I hereby release said physicians and his or her staff from all legal responsibility or liability that may arise from the release of this information or these records.

This consent will expire in ninety (90) days after the date below or sooner, at my election. I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken in reliance upon my authorization. Such revocation must be in writing. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. I understand that there may be a charge for my medical records.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____