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Description automatically generated

3016 W. Wackerly Street

Midland, MI 48640

Telephone: (989) 631-6730

Fax: (989) 631-4398

**AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS**

Patient’s Name: Date of Birth:

Maiden Name: Last four digits of SSN:

I request and authorize Dr/Facility: @Fax#:

to release my records to: @Fax#:

Reason for Request: \_\_\_\_\_ Transferring Care \_\_\_\_\_ Continuum of Care \_\_\_\_\_ Personal Use

\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please DO NOT send ALL records unless requested below.

CURRENT PREGNANCY RECORDS PRIOR PREGNANCY RECORDS

LAST TWO PAP SMEARS LAST TWO MAMMOGRAMS

OBSTETRICAL/PELVIC ULTRASOUND RESULTS MOST RECENT LAB RESULTS

LAST TWO DEXA SCAN RESULTS ALL RECORDS

OPERATIVE REPORTS \*records covering the period from: to

OTHER

I understand, as set forth in the practice’s Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the privacy officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. I understand I have the right to refuse to sign this authorization or to inspect or copy my protected health information to be used or disclosed as permitted under federal and state laws. cable State of Michigan and Federal laws. I understand these records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or substance abuse counseling, and/or HIV/ARC testing. I understand the practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient any may no longer be protected by federal or state law. Without expressed written revocation, this consent expires after one year.

SIGNATURE OF PATIENT/GARDIAN DATE

SIGNATURE OF WITNESS