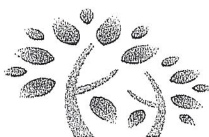

3960 West Royal Drive
Traverse City, Mi. 49684
231-947-0404 Fax 231-947-2190

AUTHORIZATION FOR RECORDS RELEASE

I hereby authorize NORTHWOOD OBSTETRICS & GYNECOLOGY,P.C. to perform the following actions:

☐ Receive records *from:*

Name of physician or office	Street address	City	State	Zip	Phone	* Fax#

☐ Release records *to:*

Name of physician or office	Street address	City	State	Zip	Phone	*Fax#

Check all that apply: ☐ Most Recent History & Physical Exam ☐ Labs, Ultrasound, xrays
☐ Operative Reports ☐ Discharge Summary ☐ Other____________________
Dates of interest: from__________ to ____________.

Please indicate the purpose for disclosing this information: ☐ Moving from area ☐ Attorney request
☐ Insurance or Disability Issue ☐ Changing Health care Provider; so that we may improve, please briefly explain the events leading to your decision to leave our practice:____________________

I hereby authorize and request the release of all my pertinent medical records, which *may* include:

- Communicable disease and infection information, as defined by statute and Michigan Dept. of Public Health Rule. This pertains to information regarding such conditions as venereal diseases, Tuberculosis, Hepatitis B, HIV and AIDS.
- Alcohol and/or drug abuse treatment information.
- Mental Health treatment records, psychological services and social services information, including communications made to me by a social worker or psychologist.

This consent can be revoked at any time in writing unless the Provider has already acted based on this contract. This consent expires after 180 days. I understand that there may be a charge for this service.

____________________ ____________ ____________
Print patient's full name & maiden name if applicable — Date of Birth — Social Security Number

____________________ ____________________
Patient's signature — Guardian or Responsible party (if applicable)

____________________ ____________________
Witness — Today's Date

***NOTE: FAX number for another entity is mandatory**