ADVANCED OB-GYN
Obstetrics & Gynecology
230 Michigan St. NE, Suite 102, Grand Rapids, MI 49503 616-971-0060

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,_____ _____
(Patient Name) (Date of Birth)

Address_____ Phone Number_____

Do hereby authorize _____

_____

To release information contained in my medical records to:

_____

_____

_____

Information to be released:

_____ All records

_____ Specific Dates: _____

_____ Specific Information: _____

I understand that unless I direct otherwise, the party above will release all medical information regarding me, including information relates to testing and/or treatment for substance abuse or dependency; psychiatric or mental treatment; information related to testing and/or treatment of HIV/AIDS.

_____ (Please initial for compliance and payment) Per office policy of Advanced OB-GYN there is a charge for records to be copied and transferred out of our office. This payment is due before records will be sent.

_____

Signature of Patient/Legal Guardian Date

_____

Witness (Employee of ADVANCED OB-GYN)

*This release will expire six months after date of signature. All information must be completed/signed/initialed/paid before release.