DVANCED OB-GYN
Obstetrics & Gynecology

230 Michigan St. NE, Suite 102
Grand Rapids, MI 49503
Phone: (616) 971-0060
Fax: (616) 301-9899

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Address _____ Phone_____

Do hereby authorize

Advanced Ob-Gyn
230 Michigan St SE, Suite 102
Grand Rapids MI, 49503
Ph 616-971-0060 Fax 616-301-9899

To release information contained in my medical records to _____
(Practice Name)

_____
(Practice Address)

_____
(Practice Fax Number)

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 related to testing and/or treatment for substance abuse or dependency, psychiatric or mental treatment, information related to testing and/or treatment of HIV/AIDS.

_____
Signature of Patient/Legal Guardian Date