AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ____ ___________________________

(Patient Name) (Date of Birth)

Address ____ Phone_____________

Do hereby authorize ____

____

To release information contained in my medical records to:

Advanced Ob-Gyn
230 Michigan St NE, Suite 102
Grand Rapids, MI 49503
Fax 616-301-9899

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.

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Signature of Patient/Legal Guardian Date