

OAKLAND MACOMB OBSTETRICS & GYNECOLOGY, P.C

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FX 586.273.7183

1701 SOUTH BLVD. EAST
Suites 200, 350, LL25 & LL50
ROCHESTER HILLS, MI 48307
PH 248.997.5805
FX 248.997.5811

4550 INVESTMENT DRIVE
Suite 200
TROY, MI 48098
PH 248.218.4073
FX 248.519.6004

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(COPY FEES MAY BE CHARGED)**

Name of Patient _____ Date of Birth _____
Address _____ Phone Number _____

I hereby authorize OAKLAND MACOMB OBSTETRICS & GYNECOLOGY to (check one)

Release to _____ OR Receive from _____

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

The information released shall include documentation from the treatment or examination rendered to during the time period of all dates of service OR _____ thru _____
(date) (date)

Purpose of Use/Disclosure: ☐ PCP ☐ Referral ☐ Insurance ☐ Moving ☐ Transfer of Care
☐ Personal Use ☐ OTHER

Type of Information to be Disclosed Consists of: ☐ Complete Record ☐ Lab Results
☐ OB Records ☐ Pap Smear ☐ Pathology ☐ US/Mammo ☐ OTHER _____

Records being sent will also include the information listed below unless otherwise checked

☐ Health Information related to drug abuse
☐ Health Information related to alcohol abuse
☐ Health Information related to psychological or psychiatric conditions, including psychotherapy notes
☐ Health Information related to HIV/AIDS

I understand that the individual I authorize to receive my medical information may not need to follow the same stringent privacy standards as Oakland Macomb Obstetrics & Gynecology, P.C. The recipient might not be subject to re-disclosure rules set forth by the Health Insurance Portability and Accountability Act (HIPPA).

RIGHT TO REVOKE

I understand this authorization may be revoked by me through written notification at any time except for any action which has already been taken. The following address is for written notification: Oakland Macomb Obstetrics & Gynecology P.C., Attention: Medical Records, 1701 South Blvd East, Suite 200, Rochester Hills, MI 48307.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated and herein.

Patient Signature (or legal representative)

Date

Witness

Approved By: _____ Date: _____

Sent/Fax'd: _____ Date: _____ FEE Charge: _____