OAKLAND MACOMB OBSTETRICS & GYNECOLOGY, P.C

36555 26 MILE ROAD
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LENOX TOWNSHIP, MI 48048
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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

medicalrecords@oamaobgyn.com

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: _____