advanced women's health specialists

Authorization to Obtain/Release Medical Records

44344 Dequindre Rd. Suite 460
Sterling Heights, MI 48314
Phone: (586) 262-5060 - Fax: (586)0262-5061

Patient Name: _____DOB: _____

Obtain:

_____ Complete Medical Record or _____ Records Pertaining To _____
(Medical problem or specific dates of treatment)

Release:

_____ Complete Medical Record or _____ Records Pertaining To _____
(Medical problem or specific dates of treatment)

___ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

This information is to be obtained from:

_____
(Name of Physician or Facility)

PURPOSE OF DISCLOSURE:

____ Continuation of Care _____
____ Change of Doctor (Street Address & Suite Number)
____ Disability Determination
____ Insurance _____
____ Legal Investigation (City, State & Zip Code)
____ Personal
____ Referral to Specialist _____
____ Workers Comp (Phone/Fax Number)
____ Other _____

Patient's Signature: _____Date: _____

Parent/Guardian (If a minor): _____Date: _____

FEE FOR MEDICAL RECORDS:
First 20 pages: $15.00
Pages 21-50: $1.00
Pages 51 and over: $0.50