





**Mary A. Durbin, MD**

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## Authorization to Release Records

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

<b>FROM:</b> <input type="checkbox"/> Mary Durbin, MD <input type="checkbox"/> Becky Lang, MD	<b>TO:</b> <input type="checkbox"/> <b>Great Lakes Bay Women's Care</b> 3175 Professional Dr. Bay City, MI 48706
	<b>TO:</b> Practice Name: _____  Fax Number: _____
<b>Medical Records to Be Released:</b>	
<input type="checkbox"/> <b>Pertinent Information</b> Include the following: <i>(Last 3 years of)</i> Medication List Office Notes Pap Smears Imaging Reports Labs All Operative Reports	<input type="checkbox"/> Office Notes <input type="checkbox"/> Labs <input type="checkbox"/> Pathology (Paps, Biopsies) <input type="checkbox"/> Imaging Reports (Mammogram, Ultrasound, DEXA Scan) <input type="checkbox"/> Operative Reports  <input type="checkbox"/> All Medical Records <input type="checkbox"/> Other: _____ _____

I hereby release the physician and her staff from all legal responsibility or liability that may arise from the release of this information or these records.

You have the right to revoke this authorization except if the action has already taken place in reliance upon this authorization. You may revoke this authorization by submitting a request in writing to: Dr. Mary Durbin or Dr. Becky Lang at the address listed above. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person.

**I acknowledge that I have read and understand this authorization. I am signing this authorization voluntarily. Further, I authorize the use and disclosure of my protected health information in accordance with the terms of this authorization.**

\_\_\_\_\_

Patient / Legal Representative Signature

\_\_\_\_\_

Date