

# GENERATIONS OB+GYN

## OBTAIN MEDICAL RECORDS

(Use this form to have an outside physician or facility send your records to Generations)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, here by, authorize this Physician/Facility \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_  
to release my requested medical records by this date \_\_\_\_\_ to the following facility

GENERATIONS OB-GYN RECORDS MANAGEMENT  
35046 WOODWARD AVE STE 100  
BIRMINGHAM MI 48009-0932  
P (248) 647-9860 x237 · f (248) 633-2110

### **INFORMATION TO BE OBTAINED**

Recent Labs and Notes     Entire Record     Other (Be Specific) \_\_\_\_\_

### **PURPOSE OF DISCLOSURE**

Personal     Insurance     Changing Physicians     Consultation /2nd Opinion     Attorney  
 Other \_\_\_\_\_

### **PATIENT AUTHORIZATION**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **EXCLUDE** the following information from the records released (*please initial*)

\_\_\_ Drug/Alcohol abuse/treatment and diagnosis                      \_\_\_ Sexually transmitted disease  
\_\_\_ HIV/AIDS diagnosis/treatment/testing                              \_\_\_ Mental illness or psychiatric diagnosis/treatment

### **MY RIGHTS**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). This authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year after date of signature. I understand that I have the right to **REVOKE** this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: \_\_\_\_\_. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. Records from Healthcare Providers other than Generations OB-GYN will not be disclosed.

By signing below, I understand that according to the rules set by the Michigan State board of Medical Examiners, Generations OB-GYN has 15 business days from the date this report was received, to provide me with an exact copy of the above requested information within my medical record. I am also aware that a fee may apply to this request and is **SOLELY** the responsibility of the patient.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient, guardian, or Authorized representative)

NOTICE: The information contained in this transaction is privileged and confidential. It is solely for the use of the recipient, named above, you are hereby notified that any dissemination, distribution, copying or disclosure of the contents of this transmission is prohibited. If you have received this transmission in error, please notify us immediately.

*Providing Excellence In Women's Healthcare*

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