GENERATIONS
OB+GYN

RELEASE MEDICAL RECORDS FORM

Patient Name _____ Date of Birth _____
Home Phone ( )_____ Cell Phone ( )_____
Address _____
City _____ State _____ Zip _____
I, here by, request my medical records be released to the following;
Physician/Facility/Patient _____
Address _____ City _____ State ____ Zip _____
Phone ( )_____ Fax ( )_____

INFORMATION TO BE RELEASED

☐ Recent Labs and Notes ☐ Entire Record ☐ Other *(Be Specific)* _____
Requested File Format: ☐ Paper ☐ CD *($45.00)*
Need By Date _____

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
___ HIV/AIDS diagnosis/treatment/testing
___ Sexually transmitted disease
___ 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.*

GENERATIONS OB-GYN FILE CENTER FAX: (248) 633-2110

Providing Excellence In Women's Healthcare

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