OBSTETRICS & GYNECOLOGY ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____Date of Birth ____/____/_____
Social Security #_____-_____-_____ Maiden/Other Name_____
Patient Address_____
Phone Number: _____

I authorize

Healthcare facility/Physician

to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).

Name to whom information may be released:

Obstetrics & Gynecology Associates

25150 Ford Road, Suite 200. Dearborn Heights MI 48127 and

16815 East Jefferson Avenue, Suite 210, Grosse Pointe, MI 48230

Phone: 313-277-0400 Fax: 313-277-0300

Date(s) of Treatment: _____

Specific Type of Information to be Disclosed :(Circle)

Discharge Summary	**Pathology Reports**	**Emergency Department Report**
History & Physical	**Radiology Reports**	**Obstetric Delivery**
Consultations	**Radiology Images/CD**	
Laboratory Results	**Operative Report**	**Other(Specify): _____**

The Purpose and Need for Such Disclosure: Continuity of Care

For mental health records, or records pertaining to HIV Infections or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. Your protected health information will be disclosed as specified in this authorization. This authorization will expire with written request. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ ___/___/____
Signature of Patient/Parent/Personal Representative Date

If you are signing as a parent, guardian, or personal representative please complete below:

Relationship to Patient Print Name