

OAKLAND MACOMB OBSTETRICS & GYNECOLOGY, P.C

1701 South Blvd East, Suite 200
Rochester Hills, MI 48307
Phone: 248-997-5805 Fax 248-997-5811

1455 South Lapeer Road, Suite 208
Lake Orion, MI 48360
Phone: 248-232-0090 Fax 248-232-0093

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(COPY FEES MAY BE CHARGED)**

Name of Patient _____ Date of Birth _____
Address _____ Phone Number _____

I hereby authorize OAKLAND MACOMB OBSTETRICS & GYNECOLOGY to (check one)

Release to _____ OR Receive from _____

Name: _____ Phone Number: _____
Address: _____ Fax Number: _____

The information released shall include documentation from the treatment or examination rendered to during the time period of all dates of service OR _____ thru _____
(date) (date)

Purpose of Use/Disclosure: ___ PCP ___ Referral ___ Insurance ___ Moving ___ Transfer of Care
___ Personal Use _____ OTHER

Type of Information to be Disclosed Consists of: ___ Complete Record ___ Lab Results
___ OB Records ___ Pap Smear ___ Pathology ___ US/Mammo ___ OTHER _____

Records being sent will also include the information listed below unless otherwise checked

- ___ Health Information related to drug abuse
- ___ Health Information related to alcohol abuse
- ___ Health Information related to psychological or psychiatric conditions, including psychotherapy notes
- ___ Health Information related to HIV/AIDS

I understand that the individual I authorize to receive my medical information may not need to follow the same stringent privacy standards as Oakland Macomb Obstetrics & Gynecology, P.C. The recipient might not be subject to re-disclosure rules set forth by the Health Insurance Portability and Accountability Act (HIPPA).

RIGHT TO REVOKE

I understand this authorization may be revoked by me through written notification at any time except for any action which has already been taken. The following address is for written notification: Oakland Macomb Obstetrics & Gynecology P.C., Attention: Medical Records, 1701 South Blvd East, Suite 200, Rochester Hills, MI 48307.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated and herein.

Patient Signature (or legal representative) Date

Witness

Approved By: _____ Date: _____
Sent/Fax'd: _____ Date: _____ FEE Charge: _____