OB-GYN Associates of Marquette, P.C.
1414 W. Fair Avenue, Suite 390
Marquette, MI 49855
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1-800-628-3333, EXT 390

Authorization for Release of Medical Record Information

Name: ____________________ Date of Birth: ____________________

Address: ____________________ Social Security #: ____________________

City/State/Zip: ____________________ Telephone: ____________________

I hereby authorize:
(Name and address of releasing facility)

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____
____
____

To release information to:
(Individual name, facility/organization and address)

____
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____
____

PURPOSE OF DISCLOSURE:
- ☐ CONTINUING CARE/TREATMENT
- ☐ PAYMENT OF CLAIM/BILLING INFORMATION
- ☐ LEGAL
- ☐ FOR PERSONAL USE
- ☐ OTHER (Specify) ____________________

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____

I specifically authorize the release of information relating to:
- ☐ Substance Abuse (including alcohol/drug use)
- ☐ Behavioral Health
- ☐ HIV Related Information (AIDS related testing)

____________________ __________
Signature of patient or personal representative date

INFORMATION TO BE RELEASED:

	Between Dates of		Between Dates of
☐ Discharge Summary	______	☐ X-Ray Reports	______
☐ Payment of Claim/Initial Evaluation	______	☐ X-Ray Films/MRI	______
☐ Consult	______	☐ Diagnostic Test Reports	______
☐ Counselor/Therapist Summary	______	☐ Procedure Reports	______
☐ Progress Notes/Provider Notes	______	☐ Lab Reports/Pathology	______
☐ Orders	______	☐ Correspondence	______
☐ Other (Specify contents and dates)	______		

ACKNOWLEDGEMENT OF UNDERSTANDING:
- I understand the expiration date of this authorization is one (1) year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations.
- I understand by authorizing this use or disclosure or information, there will be no conditions placed on my health care or payment for my health care.
- I understand I may receive a copy of this form after I signed it.
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____________________ ____________________ __________
Signature of patient, parent of minor, or personal representative Relationship Date

____________________ __________
Witness Date

OBGYN/ rev 7-14