OB•GYN ASSOCIATES OF MARQUETTE P.C.

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Marquette, MI 49855
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Authorization for Release of Medical Records Information

Name:_____ Date of Birth: _____

Address: _____Social Security #: _____

City/State/Zip Code:_____Telephone: _____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

PURPOSE OF DISCLOSURE:

- ☐ CONTINUED CARE/TREATMENT
- ☐ PAYMENT OF CLAIM/BILLING INFORMATION
- ☐ LEGAL
- ☐ FOR PERSONAL USE
- ☐ OTHER (Specify) _____

_____
_____

I specifically authorize the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug use)
- ☐ Behavioral Health
- ☐ HIV Related Information (AIDS related testing)

X_____ _____
Signature of Patient or Representative Date

INFORMATION TO BE RELEASED:

	Between Dates of
☐ Discharge Summary	_____
☐ Payment of Claim/Initial Evaluation	_____
☐ Consult	_____
☐ Counselor.Therapist Summary	_____
☐ Progress Notes/Provider Notes	_____
☐ Orders	_____
☐ All Records	_____
☐ Other (Specify contents and dates)	_____

	Between Dates of
☐ X-Ray Reports	_____
☐ X-Ray Films/MRI	_____
☐ Diagnostic Test Reports	_____
☐ Procedure Reports	_____
☐ Lab Reports/Pathology	_____
☐ Correspondence	_____

_____
_____
_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this 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 of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I received a copy of this form after I signed it.

X_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

_____ _____
Witness Date