

Valley OB-GYN Clinic, P.C.

926 N. Michigan
Saginaw, MI 48602

Authorization to Release Medical Information

Phone: (989) 753-8453
Fax: (989) 753-3519

NOTIFICATION OF PARTIES

(Sending Organization)

(Receiving Organization)

⇐ is hereby granted permission to release information as specified below contained in my patient records for the purpose of continuity of care to: ⇨

PATIENT IDENTIFICATION

Patient Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Other Last Names Used (Maiden Name, etc.) _____

Social Security # _____ Phone # _____

SCOPE OF INFORMATION: (please check only one of the boxes below)

ALL MEDICAL INFORMATION including any data regarding communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules (which include, but are not limited to sexually transmitted diseases, hepatitis b and HIV/AIDS). This authorization also includes any treatment for substance abuse or dependency, psychiatric, or mental health.

All medical information described above **WITH THE FOLLOWING EXCEPTIONS:**

ONLY the medical information described below (also include date of information)

RELEASE OF PROVIDING PARTY

I hereby release said physician and his/her staff from all legal responsibility or liability that may arise from the release of this information of these records. If necessary, I authorize this information to be sent via fax transmission.

LENGTH AUTHORIZATION IS IN EFFECT

This consent will expire on _____ or ninety (90) days after the date below or sooner, at my election. I understand that I have the right to withdraw this authorization at any time, except to extend that action has been taken in reliance upon my authorization. Such revocation must be in writing.

SIGNATURES

Patient _____ Date _____

Parent/Guardian (where appropriate) _____ Date _____

Witness _____ Date _____