



## CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Maiden Name: \_\_\_\_\_

I hereby authorize:

Name of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To disclose the following medical information to:

**South Shore Women's Health Care**

2690 South Cleveland Avenue

Saint Joseph, MI 49085

Phone: (269) 428 - 2800 Fax: (269) 428 - 7177

Information to be disclosed: (This information will NOT be released unless the appropriate box is marked)

\_\_\_\_\_ Any and all of my medical records (as of the date of this release)

\_\_\_\_\_ Any and all of my records **except** the following: \_\_\_\_\_

\_\_\_\_\_ Mammogram Films: \_\_\_\_\_

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

This statement may be revoked, but not retroactive to the release of this information made in good faith. I understand that if my record contains items related to mental health (anxiety or depression), alcohol or drug usage (including tobacco), testing for sexually transmitted diseases, HIV, or AIDS, it will be included as part of your request. These items will only be excluded if requested, in writing, in this form.

Reason for release: (Please mark one)

Relocated/Relocating

Personal Use

Insurance Changed

Changing Medical Doctors

Consultation Purposes

Other: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient or Legal Representative

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Staff Witness

Mailed  Faxed  Picked Up Date: \_\_\_\_\_

Fax: \_\_\_\_\_