South Shore Obstetrics & Gynecology Women's Health Care

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____ **Phone:** _____

_____ **Maiden Name:** _____

I hereby authorize: South Shore Women's Health Care
2690 South Cleveland Avenue
Saint Joseph, MI 49085
Phone: (269) 428 - 2800 **Fax:** (269) 428 - 7177

To disclose the following medical information to:

Name of Provider: _____

Address: _____

_____

Phone: _____ **Fax:** _____

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
- ☐ Insurance Changed
- ☐ Consultation Purposes
- ☐ Other: _____
- ☐ Personal Use
- ☐ Changing Medical Doctors

_____ _____ _____

Printed Name of Patient or Legal Representative **Signature of Patient or Legal Representative** **Date**

_____ ☐Mailed ☐ Faxed ☐Picked Up Date: _____

Office Staff Witness Fax: _____