Eastside GYNECOLOGY OBSTETRICS

29751 Little Mack
Suite B
Roseville, Michigan 48066
586-415-6200
586-415-6217 Fax

Medical Record Release

Patient Full Name: _____ Maiden Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ DOB: ____/____/_____

I _____ hereby request and authorize the release of my protected health information (as directed below):

Records *FROM*: Eastside Gyn/OB _____

29751 Little Mack Avenue, Ste. B

Roseville, MI 48066_____

586.415.6200 586.415.6217

Records *TO:* _____
Name of Physician/Practice

_____
Address

_____
City, State, Zip

_____
Phone Fax

Information contained in my medical records, including alcohol and drug abuse records are protected under the regulations, 42 code of Federal Regulations (CFR) Part II, as well as psychological service records/psychiatric records, if any. The specific nature or extent or information to be disclosed is:

- ❑ Chart Notes _____
- ❑ Paps/Mamm _____
- ❑ X-Ray/Lab _____
- ❑ Other (specify) _____
- ❑ Entire record since _____ (need to indicate reason)

_____

Note: I expressly authorize information concerning the following serious communicable disease(s) to be released (check all that apply)

- ❑ HIV test results
- ❑ AIDS related complex (ARC)
- ❑ AIDS test results

This health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

- ❑ Change in OB-Gyn Physician **
- ❑ Insurance Change
- ❑ Primary Care Physician
- ❑ Referral Physician/Second Opinion
- ❑ Moving/New Address
- ❑ Life Insurance Disability

This authorization is effective on the date of signature for 60 days unless revoked by me in writing.

Please note: A processing fee may be assessed for the release of your records – the fee of MI Statute is as follows: $23.62 initial fee. $1.18 per page for the first 20 pages. $0.59 for pages 21-50. $0.24 per page after 51 pages. COPY FEE: *Pursuant to Michigan Law establishing reasonable fees for copying medical records, Subsection 1 and Subsection 6 of Section 9 of Public Act 47 of 2004 (MCL 333.26269),* ***we reserve the right to charge for the cost of producing the copies. This payment is due upon receipt of records.***

Patient Signature: _____ Date _____

Parent/Guardian (if patient is a minor): _____

Date: _____ Witness: _____

Use this form for records leaving our office