



# Women's Medical Center, P. C.

Obstetrics & Gynecology  
1201 South Drive Suite 220  
Mt. Pleasant, Michigan 48858  
(989) 773-3411 Fax: (989) 775-3187

Jerry Elliot, M.D.  
Steven Podolsky, M.D.  
Michael Swirtz, M.D.  
Robin O'Dell, D.O.  
Michelle Sanders, D.O.

## Records Release Form

NAME \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient's New Address/Phone \_\_\_\_\_

FROM \_\_\_\_\_ PH: \_\_\_\_\_

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

TO: Women's Medical Center, P.C. Phone: 989-773-3411 Specify Doctor: \_\_\_\_\_  
1201 South Drive, Suite 220 Fax: 989-775-3187  
Mt. Pleasant, Michigan 48858

Specific Records Requested:  All (last 5 yrs, unless otherwise specified below)  Last 2 yrs  
 Mammogram  Recent pap/Annual notes  OB records  Office notes  
 Complete Chart  Other (Specify if not covered above) \_\_\_\_\_

Reason for Request:  Transfer/Moving  Continuation of Care  Vacation  
 Referred  Insurance Reasons  Other \_\_\_\_\_

I hereby authorize and request the release of my medical records, including as applicable:  
• Communicable disease and infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B., human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC") and (specify other, if known)  
• Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.  
• Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

This consent can be revoked in writing at any time unless the provider has already acted in reliance upon its continued effectiveness. With expressed written revocation, this consent expires after 180 calendar days. I UNDERSTAND THERE MAY BE A CHARGE FOR THIS SERVICE.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or Guardian)

Witness \_\_\_\_\_