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

TO _____ **PH:** _____

Address _____ **FAX:** _____

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 _____