Somerset Gynecology & Obstetrics
3290 W. Big Beaver Ste. 444
Troy, MI 48084
Phone 248-816-9200 Fax 248-816-1017

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Last	First	Middle
Address		
Date of Birth	Home Phone	Cell Phone

Record Released From:
Name: _____ Address: _____

Phone: _____ Fax: _____

Records Released To:
Name: _____ Address: _____

Phone: _____ Fax: _____

- ☐ The entire medical record and history of care.
- ☐ Portions of the medical record for the period _____ to _____ including:
- ☐ Any diagnostic information (diagnoses, lab and diagnostic tests and results);
- ☐ Specific diagnosis: _____:
- ☐ Office and progress notes for the period indicated
- ☐ Hospital admissions and discharge summaries
- ☐ Hospital notes
- ☐ Operative reports, notes, findings

I understand and agree that the patient records released may include:

- Alcohol and drug abuse information protected under the regulation in 42 Code of Federal Regulations, Part 2, if any; and,
- Psychological and/or social service information, if any; and,
- Information about HIV, AIDS, or ARC protected under MCL333.5131, or any communicable disease.

This authorization is valid for a maximum of two (2) years from the date of the signature below or until expressly revoked by the undersigned.

_____ _____
Patient's Name **(Please Print)** Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

It is our office policy to charge a fee for the copying of medical records.
Your charge is _____**.** This request will be processed once payment is received. Please be advised that records may take up to 4 weeks to process.