South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ **Date of Birth** _____
Address _____ **Phone**_____
_____ **Maiden Name** _____
Chart #

I hereby Authorize: Name of Provider: **South Shore Women's Health Care**
Address: **2690 South Cleveland Avenue**
St. 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.)

_____ Most recent; H&P, Labs, Pap, Bone Density, & Mammogram image(s) & report(s)
_____ Any and all of my records (as of this date of release):_____
_____ Any and all of my records ***except*** the following: _____
_____ Mammogram image(s) & report(s): _____
_____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, on 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 By:_____