South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ **Birthdate** _____ **Account #** _____

Address _____ **Phone**_____

_____ **Maiden Name** _____

I hereby Authorize:

Name of Provider_____

Address_____

_____

Phone _____ Fax _____

To disclose the following medical information to:

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**

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 reports

_____ Any and all of my medical record (as of the date of this 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 ☐ Personal Use

☐ Insurance Changed ☐ Changing medical doctors

☐ Consultation purposes

☐ Other: _____

_____ _____ _____

Printed Name of Patient or Legal Representative Signature of Patient or Legal Representative Date

_____ ☐ Mailed ☐ Faxed ☐ Picked Up Date: _____

Office Staff Witness By: _____