

CONTEMPORARY OBSTETRICS AND GYNECOLOGY, P.C.

Richard S. Duff, M.D., FACOG

Andrea C. Blake, M.D., FACOG

Brian K. Reedy, M.D., FACOG

Daniel J. Greene, M.D., FACOG

Sapna Murthy, M.D., FACOG

Dawn M. Goulding, M.D., FACOG

Jennifer S. Myers, MSN, WHNP

BOARD CERTIFIED OBSTETRICS AND GYNECOLOGY

www.contemporarydoctors.com

1202 Walton Blvd., Suite 216
Rochester, MI 48307
Phone: (248) 656-2022
Fax: (248) 656-4865

72 S. Washington, Suite 106
Oxford, MI 48371
Phone: (248) 860-3915
Fax: (248) 656-4865

58851 Van Dyke, Suite 600
Washington, MI 48094
Phone: (586) 992-9567
Fax: (586) 992-9568

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Other Last Name Used: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED: TO **--or--**

(check appropriate boxes)

FROM

RICHARD S. DUFF, M.D. BRIAN K. REEDY, M.D. SAPNA MURTHY, M.D.

ANDREA C. BLAKE, M.D. DANIEL J. GREENE, M.D. DAWN M. GOULDING, M.D.

JENNIFER S. MYERS, MSN

TO **-- or --** FROM

FEE for Medical Records
Initial Fee: \$21.20
First 20pgs: \$1.06
Pgs 21-50: \$0.53
Pgs 51 and Over: \$0.22
Postage Fee:

NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE _____
FAX _____

Contemporary Obstetrics and Gynecology, P.C., is authorized to release my health care information relating to the following treatment, condition or dates of treatment that they provided:

Please list reason for transfer: (example: moving, insurance, etc.)

I understand health records in my file obtained from other healthcare entities may not be included in this request. I understand that my express consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing or treatment. The information requested may be faxed.

THIS AUTHORIZATION EXPIRES 90 DAYS FROM DATE SIGNED

Signature of patient or authorized representative

Date Signed

Relationship to patient, if not patient