

Women First OB/GYN Center  
326 N. Main Street  
Royal Oak, Michigan 48067  
Phone: (248) 584-7600 Fax: (248)584-7606  
Email: [records@women-firstobgyn.com](mailto:records@women-firstobgyn.com)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please send the following:

All Medical Records

Specific Records: \_\_\_\_\_

I will pick up copies of my records  Fax Records  Mail Records  Email Records

I hereby give permission to send the above records:

From  To

From  To (please put name of office, address, phone/fax number, email)

Women First OB/GYN Center  
326 N. Main Street  
Royal Oak, MI 48067

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the patient's file is more than 30 pages, please mail to our office. Thank you.

**Reason For Request:**

I am leaving the practice (Reason for Leaving) \_\_\_\_\_

I am seeking a specialist and my appointment is: \_\_\_\_\_  Health/Life Insurance

Disability Benefits  Other: \_\_\_\_\_

Please be advised that an initial fee of \$20.00 per request (pgs 1-20)\$ .50 per page 21 and over (subject to WFOB/GYN rates). **Please be aware if you have a balance with us, it needs to be paid in full before we can release your records.**

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian or Personal Representative