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

Patient Name: ______________________________ DOB: ______________

Address: ____

City, State, Zip: ______________________________ Phone Number: ____________

Please Note: Copy Fee of $20 May Be Charged For Medical Records. Please be aware if you have a balance with us, it needs to be paid in full before we can release your records.

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

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

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

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If the patient's file is more than 40 pages, please mail them to our office.
*****WE CAN NOT ACCEPT CD'S*****

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:______________________________

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.
This authorization expires on: ____________________. If the expiration date is left blank, the authorization expires 60 days from the signature date.

______________________________ ______________________
Signature of Patient Date

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Signature of Parent/Guardian or Personal Representative