Partridge Creek
Obstetrics & Gynecology

15959 Hall Road, Suite 301
Macomb, MI 48044

Phone: 586-247-8609
Fax: 586-247-8615
e-Fax: 586-247-8613

MEDICAL RECORDS RELEASE

Name of Patient: _____ SSN: _____ Birthdate: _____

I hereby authorize the release of the requested medical records below:

From: **Partridge Creek Obstetrics and Gynecology**
Rhonda L. Kobold, DO
Beth K. Mutch, MSN, FNP-BC
Teressa C. Kuz, MSN, WHNP-BC
Tanya M. Vaughn, MS, CNM, FNP-BC

To be sent to: _____
_____
_____

Type of information requested:

OB/Gyn records
Ultrasound / Radiology reports
Laboratory/ Pathology results
Other: _____

These records are being released for the following reason:

_____ Treatment of patient
_____ Moving to a new area
_____ Transferring (patient outgrown pediatric age)
_____ Changing Insurance; please list insurance plan _____
_____ Transferring to a new physician due to dissatisfaction with:
_____ Waiting time in office _____ Patient care
_____ Interactions with staff _____ Scheduling problem
_____ Other: _____

I authorize the release of medical records including immunization records, HIV testing/results, mental health records, drug dependency records and any infectious diseases, including sexually transmitted diseases.

_____ _____
Signature (Patient or Guardian) Witnessed by

_____ _____
Date Date