Partridge Creek
Obstetrics & Gynecology

19991 Hall Road, Suite 105
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: _____
_____
_____

To be sent to: **Partridge Creek Ob/Gyn**
_____ **Rhonda L. Kobold, DO**
_____ **Hina Javaid, MD**
_____ **Beth K. Mutch, MSN, FNP-BC**
_____ **Teressa C. Kuz, MSN, WHNP-BC**
_____ **Tanya Vaughn, MS, CNM, FNP-BC**

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.

I can cancel this authorization at any time by written request to Medical Records /Health Information Department at Partridge Creek Obstetrics & Gynecology, P.C. I understand that once this information has been released it can not be recalled. This authorization will expire 1 year from the date signed below unless another date or event is entered here _____

_____ _____
Signature (Patient or Guardian) Witnessed by

_____ _____
Date Date