# MEDICAL RECORDS RELEASE TO OUR OFFICE

## Dr. Beals and Dr. Rehm

Patient Name:_____ DOB:_____

| **FROM**: Physician/person/facility to release records: | **TO**: Dr. Beals and Dr. Rehm |
|---|---|
| Name_____ | 390 Park St Suite 109 |
| Address_____ | Birmingham, MI 48009 |
| City/State/Zip_____ | Phone: 248-647-5660 |
| Phone_____Fax_____ | Fax: 248-647-2664 |

- ☐ Entire medical record: Office visit notes, labs, ultrasounds, mammograms
- ☐ Last 5 years
- ☐ Most recent office visit: office notes, pap report, labs, or mammograms
- ☐ OB records: prenatal labs, ultrasounds, office notes:
  - Current pregnancy
  - Previous pregnancies: including delivery summary
- ☐ Specific/other records:_____
  _____

I agree and understand:

- I have the right to withdraw this authorization
- I do not have to sign this authorization to receive treatment
- The information which I have authorized for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- I may be charged a fee for records requested
- This authorization is voluntary

**This authorization expires 12 months from the date it was signed OR as specified: ___/___/___**

_____ Date:_____
Patient signature (parent or legal guardian)

_____ Date:_____
Witness Signature