MEDICAL RECORDS RELEASE FROM OUR OFFICE

Dr. Beals and Dr. Rehm

Patient Name:_____ DOB:_____

FROM: Dr. Beals and Dr. Rehm	**TO:** Physician/facility to release records to:
390 Park St, Suite 109	Name: _____
Birmingham, MI 48009	City/State/Zip: _____
Phone: 248-647-5660	Phone: _____
Fax: 248-647-2664	Fax: _____

- ☐ 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