**VALLEY OB-GYN. CLINIC, P.C**

**926 N. Michigan Ave., Saginaw, MI 48602 Phone: 989-753-8453 Fax Completed Form: 989-341-5076**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: |  | Date of Birth: |  |
| Previous Name: |  | Social Security #: |  |
| Patient Phone No: |  | Reason for Release: | * FMLA &/or Disability($30/ form)
* Transferring Care
* Prenatal Review
* Continuation of Care
 |
| **I Request and Authorize:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Release healthcare information of the patient named above to: |
|  | Name: | Valley OB-Gyn, P.C. Clinic, 926 N. Michigan Ave., Saginaw, MI, 48602 |
| This request and authorization applies to: |
|  Healthcare information relating to the following treatment, condition, or dates: |  |
|  |  |
|  All healthcare information |
|  Other: |  |
| Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. |
|  |
|  Yes  No | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. |
|  |
|  Yes  No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. |
| Patient Signature: |  | Date Signed: |  |
| THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS REVOKED IN WRITING SOONER BY PATIENT OR PATIENT’S AUTHORIZED GUARDIAN OR LEGAL REPRESENTATIVE. |

Search Fee: $25.00\* Pages 1 - 20 : $1.25 per page Pages 21 - 50 : $0.63 per page Pages 51+ : $0.25 per page
Fees Authorized by Michigan Law: [Public Act 47 of 2004. MCL 333.26269](https://www.michigan.gov/documents/mdch/Medical_Records_Access_Act_Fees_2015_481989_7.pdf). (Search fee waived for patient request their own record).