INBOUND

926 N. Michigan Ave., Saginaw, MI 48602

Phone: 989-753-8453 Fax Completed Form: 855-660-7762

form Transferring Care Prenatal Review Patient Phone No: Release: Continuation of Car Prenatal Review Release: Continuation of Car I Request and Authorize: Name: Address: City/State/Zip: Phone: Fax: 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: Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphil chancroid, lymphogranuloma venereuem, HTV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.			Date of Birth:	
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☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or posithe person(s) listed above. I understand that the person(s) listed above will be notified must give specific written permission before disclosure of these test results to anyone	□ Other: Definition: Sesimplex, human chancroid, lymp	exually Transmitted Disease (STD) as n papilloma virus, wart, genital wart, c phogranuloma venereuem, HIV (Huma	defined by law, RCW 70 condyloma, Chlamydia, n	on-specific urethritis, syphilis, VDRL,
\square Yes \square No I authorize the release of any records regarding drug, alcohol, or mental health treatre the person(s) listed above.	□ Other: Definition: Sesimplex, human chancroid, lymp	exually Transmitted Disease (STD) as a papilloma virus, wart, genital wart, conogranuloma venereuem, HIV (Humancy Syndrome), and gonorrhea. I authorize the release of my STD the person(s) listed above. I under	defined by law, RCW 70 condyloma, Chlamydia, n an Immunodeficiency Vir presults, HIV/AIDS testinerstand that the person(s	on-specific urethritis, syphilis, VDRL, rus), AIDS (Acquired ag, whether negative or positive, to b) listed above will be notified that I
Patient Signature: Date Signed:	□ Other: Definition: Sesimplex, human chancroid, lymp (mmunodeficien) □ Yes □ No	exually Transmitted Disease (STD) as a papilloma virus, wart, genital wart, conogranuloma venereuem, HIV (Humancy Syndrome), and gonorrhea. I authorize the release of my STD the person(s) listed above. I under must give specific written permiss	defined by law, RCW 70 condyloma, Chlamydia, nan Immunodeficiency Viron Presults, HIV/AIDS testinerstand that the person(sion before disclosure of	on-specific urethritis, syphilis, VDRL, rus), AIDS (Acquired ag, whether negative or positive, to s) listed above will be notified that I these test results to anyone.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Search Fee: \$25.00* Pages 1 - 20 : \$1.25 per page Pages 21 - 50 : \$0.63 per page Pages 51+ : \$0.25 per page

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS REVOKED IN WRITING SOONER BY PATIENT'S AUTHORIZED GUARDIAN OR LEGAL REPRESENTATIVE.