Northpointe

Obstetrics & Gynecology, P.C.
Competent, compassionate health care for women.

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PATIENT'S AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

Request to obtain records for:

Name: _____

Address: _____

Phone: _____ D.O.B._____

SS#: _____ Other Name: _____

The undersigned hereby authorizes and requests _____ to provide to **Northpointe OB/Gyn** access to my medical/hospital records for the purpose of review and examination. I further authorize and request that you provide such copies thereof as may be requested, including as applicable:

☐ Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of code of Federal Regulations Part II.

☐ Information about human immunodeficiency virus-HIV, acquired immunodeficiency syndrome-AIDS, and AIDS related complex - ARC, as defined Department of Public Health rules (1989 Public Act 174).

SPECIFIC INFORMATION TO BE DISCLOSED AND ANY LIMITATION:

_____

_____

PURPOSE AND NEED FOR SUCH DISCLOSURE: OB/Gyn Care / Patients Request (circle one)

I understand that this authorization will automatically expire once the purpose for which it was signed is accomplished. I also understand that I may revoke this authorization in writing at any time, unless some action has been taken by Northpointe Obstetrics & Gynecology, P.C. based on this consent. Without my expressed written revocation this consent will expire 180 days from the date of signature below.

I have read the above and acknowledge that I fully understand the terms and conditions of this authorization.

Signature: _____ Date: _____

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