Contemporary
OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Last 4 of Social Security #: _____ Phone Number: _____

I hereby request that my medical records be release: ☐ TO (or) ☐ FROM
(check appropriate boxes)

☐ Richard S. Duff, M.D. ☐ Daniel J. Greene, M.D. ☐ Lauryn Przeslawski, D.O
☐ Ariel Gruda, D.O

☐ TO (or) ☐ FROM: Name:_____
Address:_____
City/State/Zip: _____
Phone:_____ Fax: _____

Contemporary Obstetrics & Gynecology, PC, is authorized to release my health care information relating to the following treatment, conditions or dates of treatment that they provided: (i.e., all records, recent test results (specify), etc.)

_____

Please list reason for transfer: (i.e., moving, insurance, transfer of care, etc.)

_____

Fee for Medical Records: Initial Fee $23.32 / First 20 pages: $1.16 each / Pages 21-50: $0.58 each
Pages 51-Over: $0.23 each / Postage Fee: To Be Determined
(Once fee is calculated, you will be contacted for prepayment)

I understand health records in my file obtained from other healthcare entities may not be included in this request. I understand that my express consent is required to release any healthcare information related to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing or treatment.

THIS AUTHORIZATION EXPIRES 90 DAYS FROM DATE SIGNED

_____ _____
Signature of Patient or Authorized Representative **Date Signed**

_____
Relationship to Patient, if not Patient

Please Fax or Mail records to
1135 W. University Dr, Ste 100
Rochester Hills, MI 48307
Ph: (248) 656-2022
Fax: (248) 656-4865