Michigan Reproductive Medicine

41000 Woodward Ave., Suite 100 East, Bloomfield Hills, MI 48304
Michael S. Mersol-Barg, M.D., Director
Phone: 248-593-6990, Fax: 248-593-5925

AUTHORIZATION TO RELEASE PATIENT INFORMATION TO

PLEASE PRINT **MICHIGAN REPRODUCTIVE MEDICINE****

I, _____ _____, hereby authorize
(Print Your Name) (Your Area Code & Phone Number)

_____ or his/her/its designee, to release information or a copy of:
(Print Your Doctor's or Hospital's Name)

_____ records, including alcohol and drug abuse records protected
(Print Patient's Name)

under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any; and psychiatric record, if any; record of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), if any; and records of communicable disease, if any; to Michael S. Mersol-Barg, M.D. and/or the Michigan Reproductive Medicine, only under conditions listed below.

_____ _____
Birth Date of Patient

RECORDS TO BE RELEASED

☐ **All Records**
☐ **Other**
(Specify)_____

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐ **Continuation of Care or Consultation** **Date of Appointment:** _____

☐ **Other** **Specify:** _____

This authorization is subject to written revocation at any time except to the extent that Michigan Reproductive Medicine has already taken action in reliance of the authorization.

_____ _____
Your Signature Date

_____ _____
Witnessing Signature Date

PLEASE EMAIL OR FAX ALL REQUESTED RECORDS TO:

Michigan Reproductive Medicine

41000 Woodward Ave., Suite 100 East, Bloomfield Hills MI 48304

forms@MiReproductiveMedicine.com or FAX: 248-593-5925

****IMPORTANT****

This AUTHORIZATION TO RELEASE PATIENT INFORMATION form must be completed by the patient or personal representative. PLEASE SUBMIT THIS COMPLETED FORM TO THE DOCTOR OR HOSPITAL WHERE YOUR RECORDS ARE LOCATED so that your records are sent to the Michigan Reproductive Medicine as soon as possible. You should copy this form if you have records with more than one doctor or hospital.