NORTHPOINTE

OBSTETRICS & GYNECOLOGY, P.C.

1206 Washington Ave, Port Huron, MI 48060

(810)984-3100 FAX (810)984-1656

Karen L. Niver, M.D., Jon P. Lensmeyer, M.D. Amanda Hurtubise, M.D.

Stacey Tremp, D.O. and Jenny Giles, PA-C

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 **Northpointe Ob/Gyn** to provide to _____ medical/hospital records for the purpose **Transferring care**. I further authorize and request that you provide such copies thereof as may be requested, including as applicable:

Please initial

☐ 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:

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 anytime, 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.

Date:_____ Signature:_____

Date:_____ Witness:_____