



# Petoskey Gynecology & Infertility

2810 Charlevoix Avenue

Petoskey, Michigan 49770

(231) 487-0970 fax (231) 487-0979

www.petoskeygyn.com

Clare B. Heidtke, M.D.

Karen Sussman, WHNP

## CONSENT TO RELEASE MEDICAL INFORMATION

\_\_\_\_\_  
(Patient's Last Name)

\_\_\_\_\_  
(First Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date of Birth)

### Physician/facility releasing records:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

### Physician/person to receive records:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

### Please release the following information to Petoskey Gynecology & Infertility:

#### Records of **Gynecologic care** if checked below:

- Breast and pelvic exams for the past 2 years
- Most recent 2 pap smear reports and any abnormal in the past
- Most recent 2 mammogram reports
- Most recent report of lipid profile and CBC
- Ultrasound reports
- Operative Notes
- Pathology Reports

#### Records of prior **Obstetric care** if checked below:

- Lab reports
- Ultrasound reports
- Operative or Delivery Notes
- Pathology reports

#### Records of **Infertility Treatment**:

- Consultation or Progress Notes
- Lab work
- Ultrasound, HSG Reports
- Ovulation Induction Records
- Operative Notes
- Pathology Reports

#### **Hospital Records**, including:

- Operative Notes from surgery
- \_\_\_\_\_ Pathology Report from \_\_\_\_\_
- Ultrasound, CT Scan, MRI (films or disc)
- \_\_\_\_\_

I authorize medical information to be released as indicated above. This applies to all information in my records protected under the regulations in 42, Code of Federal Regulations, Part 2. I understand this release is effective until \_\_\_\_\_, but that I may revoke my consent at any time by providing written consent to the above named party.

\_\_\_\_\_  
( Patient or Patient's Legal Guardian )

\_\_\_\_\_  
( Date )

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)