Request to Transfer Medical Records

Patient Name:_________________________ Date of Birth:_______________________________

Address:_____________________________ City/State/Zip :_____________________________

Phone No:____________________________

Please Note: A fee may be charged for this request.

The records to be release or disclosed are as follows:

- 2 years prior from last date seen:____________________________
- Specific Information Requested: _____________________________
- Records between the dates of ___________________and______________________

Above listed patient authorizes the following healthcare facility to make record disclosure:

From: Mark OBrien MD PLC_____________ To:______________________________

______4070 Lake Dr # 201______________ _________________________________

____Grand Rapids, MI 49546____________ Fax #:____________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be forwarded unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information released under this authorization may be re-released by the recipients.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it. Expiration date:________________, unless otherwise stated, this authorization will expire in 180 days from the date signed.

Signature of Patient or Legal Representative_______________________________

Date:___________________ Relationship to Patient_________________________