PEDIATRICS, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The below is to ensure your right to privacy. Please complete in its entirety.

I authorize_____to release the following medical information regarding:
(Name of physician/facility)

Name:_____Birth Date:_____

To: PEDIATRICS, PC
670 MALL DRIVE
PORTAGE, MI 49024

(Please initial appropriate line)
_____Any and all of patient's chart notes (as of the date of this release) or include
_____Specific records listed below:
_____
_____

This release also specifically allows the release of the following information (this information will be released unless the appropriate line is initialed):
_____Any record of treatment for drug and/or alcohol dependency or abuse;
_____Any record of mental health treatment;
_____Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only:_____ and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for one (1) year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above-named party.

_____	_____	_____
Patient/Legal Guardian	Date	Phone Number

_____	_____
Address	City – State – Zip Code