

**AUTHORIZATION FOR RELEASE/REQUEST OF A CHILD'S PROTECTED MEDICAL RECORD
(One Sheet Per Record Request)**

Patient FULL Name: _____ **Date of Birth:** _____

Name of the Person and relationship to the patient making this request:

FULL Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone/Cell: _____ Relationship: _____

As the biological parent or guardian of the patient identified above, I authorize _____ to disclose or provide protected health information about my child

TO:

Facility Name: **Southside Pediatrics** Facility Phone: 269-818-1020

Address: 300 Meadow Run Drive Facility Fax: 269-818-1266

City, ST, Zip: Hastings, MI 49058

Provider Name: _____

Transferring Provider Office Information:

Facility Name: _____ Phone: _____

Address: _____

Provider Name: _____ FAX: _____

Purpose of Medical Release: * Fees may apply if the record exceeds 50 pages or more.

<input type="checkbox"/>	Transfer of Medical Record	<input type="checkbox"/>	Coordination of Care
<input type="checkbox"/>	Insurance Claim	<input type="checkbox"/>	Litigation
<input type="checkbox"/>	School Release	<input type="checkbox"/>	Referral
<input type="checkbox"/>	Personal- As requested	<input type="checkbox"/>	

Release Method Requested: _____ Paper/ USPS Mailing _____ Fax, provide # _____ - _____ - _____

Other: _____

Please check or specify requested information below:

<input type="checkbox"/>	ALL Health Information	<input type="checkbox"/>	Medical Summary	<input type="checkbox"/>	Immunizations
<input type="checkbox"/>	Lab Reports	<input type="checkbox"/>	Sick Visits	<input type="checkbox"/>	Well Child Visits
<input type="checkbox"/>	Growth Charts	<input type="checkbox"/>	Hospitalizations	<input type="checkbox"/>	Imaging Reports
<input type="checkbox"/>	ER/Urgent Care	<input type="checkbox"/>	Allergy Shots Schedule	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	Sexual Health	<input type="checkbox"/>	Alcohol/Substance Abuse or Treatment		

Note: We will process your request as quickly as possible. Some records are storage off site in a secure facility. Please allow 60 days for the collection, copying and mailing of your child's medical record.

Conditions:

1) I understand that the health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS) and or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____

I don't want the following records released: _____

2) I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing. Send your request to _____ attention: Medical Records. I understand that stopping this authorization will not apply to information that has already been released or disclosed. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

3) I understand that information used to disclose pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read the above foregoing Authorization for Release of Medical Record Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

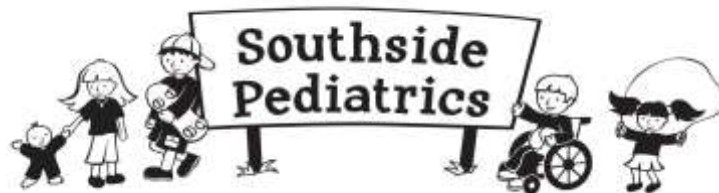
X _____ **Date** _____

Signature of Patient/ Parent/ Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

Print Name of Authorized Representative

Relationship/Capacity to patient

Address and telephone number of authorized representative



300 Meadow Run Drive, Hastings, MI 49058
(269) 818-1020 (269) 818-1266