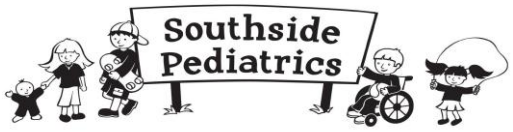

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION **Expiration Date:** _____

Patient Name (Last, First) _____

Address: _____

City,State, Zip:_____

Date of Birth: _____ Phone# _____

I AUTHORIZE THE DISCLOSURE OF MY CHILDS HEALTH INFORMATION
FROM: _____
Address: _____
City: _____
Phone: _____
Fax: _____

As the biological parent or guardian of the patient indentified above I authorize the entity listed above to disclose or provide protected health information about my child to:

TO

Southside Pediatrics, Dr Carrie Wilgus & Dr. Abby St. Jacques
300 Meadow Run Drive
Hastings, MI 49058
(269) 818-1020 fax: (269) 818-1266

Purpose of discloser: AS REQUESTED _____ **TRANSFER OF MEDICAL RECORD** _____

☐ **All Information Contained in the Medical Record** (including but not limited to listed below)

OR

☐ **ONLY the specific information checked below:**

☐	Office Visits	☐	Medical Summary
☐	Lab Reports	☐	Physical/Mental Illness
☐	Well Child Visits	☐	Alcohol/Substance Abuse or Treatment
☐	Immunizations	☐	Growth Charts
☐	ER/Urgent Care Reports	☐	Allergy Shot Schedule
☐	Hospitalization Reports	☐	Sexually Transmitted Disease Information
☐	Imaging Reports	☐	Info from other healthcare providers/facilities

I ACKNOWLEDGE that if the person/entity that receives this information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed by them and no longer is protected b the Privacy regulations. The information you authorize for release may include information that could be considered information about communicable or non-communicable disease which may include but is not limited to, diseases such as hepatitis,syphillis, gonorrhea and HIV, also known as AIDS.

_____ Date:_____
Parent/Legal Guardian Signature REQUIRED

_____
Please Print Name Above